Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY 29, 2010 Physician/ 7:05P. JAHEDA BEGUM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Days 215-35-7790 1 M 2 XF Hours Min. Nowonth, Pay, 1947 62 **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Village Maryland Montgomery Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8412 Saint Regis Way 20886 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11 Marital Status 14. Bace - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 🕅 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Indian If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5;+) Elementary/Seconday (0-12) own home housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kader Buksh Feka Begum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1 and 2 s f Health item 27 i Azizul Athar - husband 8412 Saint regis Way Montgomery Village, MD 20886 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or o cemetery, crematory or other place) 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington Cemetery 1/30/2010 Adelphi, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Bonald V. Borgwardt Funeral Home, Varille 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ovarian Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impry that initiated events Examine Due to (or as a consequence of) the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo 4 Pregnant 9 Unknown Month Dav Pregnant at time of death 5 Other (specify) detached g Unknown Division of Vital Records, P.O. þ s been signed by should be detr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy performed Yes 2 2 2X No After this certificate 1 Yes funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 2 XNo မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation s after death the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital 24 hours Funeral Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year) D64983 January 30, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Park Drive, #200 Silver Spring, Maryland 20902 Kashif Frozvi 2101 31. Date filed (Month, Day, Year, State FEB 1 7 2010

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2:00 A February 3, 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Grantsville Garrett Goodwill Mennonite Home Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Oct. 10, If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Days Hours **Funeral** 1 □ M 2**X** F Maryland 1910 Yrs 99 Director 577-24-1926 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10h County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If the Medical Evants of other traumatic event, If the Medical Evants of other traumatic event, If the Medical Evants of the modified at 1 Ves 2 No Director Washington DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20032 424 Oakwood St., S.E. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify Specify: 3altimore, Maryland 21215-0036 White 2 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Bookkeeper 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Beitzel Wilhelm Zinkan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 424 Oakwood St., S.E., Washington, DC 20032 William J. Hetrick/Nephew 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 5, 2010 Accident, MD Zion Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee P.O. Box 275, Grantsville, MD euma Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) YEARS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physiclan and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 Ø No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 2 should Completed been 24a. Was an has

certificate ha irector, page 2

Be (

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Certification:

ical

State Registrar 29a. Certifier

this

After t

filled in by the f

within 24 hours a

autopsy perform 1 ☐ Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes

26. Place of Death (Check only one) 25. Was case referred to medical examiner? 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Injury 28c. Injury at Work? 1 ☐ Yes 2 🗌 No

28d. Describe how injury occurred

5 Pending investigation Natural 2 Accident 6 ☐ Could not be 3 Suicide determined 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Destroying Engagement of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Margalet 32.

31. Date filed (Month, Day, Year) Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** David Charles Blanchard January 21 2010 0935 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 16, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex Funeral Months Days Hours Min. 1X M 2 □ F 1939 Maine Director 70 021-30-7713 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it a Madical Examinat must be recitive at 1 ☐ Yes 2 ☑ No Director MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 760 Holliday Lane 21157 USA Completed by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, if a Medical Experiment once. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📆 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)

Computer Systems Analyst

Physician) /Medical Examiner

Box 68760,

Division of Vital Records, P.O.

Be

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17. Father's Name (First, Middle, Last)

Charles Blanchard

burial-tran attending physician for use as the burial certificate has been signed by the rector, page 2 should be detached funeral director, After this

The law requires that the death certificate be executed death, spital or Attendi nours after death, neral Director; A

To the Hospital within 24 hours a To the Funeral C completely filled WJL 10+1VA State

Physician/Medical Completed Be Certification: To

Examiner

19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Blanchard wife 760 Holliday Lane Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/27/2010 Evergreen Memorial Finksburg, Maryland 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21. Signature of Funeral Service Licens 412 Washington Rd. Westminster, MD 23a. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): it any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed' 2 No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 \sum Nursing Home 5 \subseteq Residence 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Man of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23d. Date of delivery

24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No

Month

Social Security

21157

Approximate Interval Between Ons a and Death

Year

18. Mother's Name (First, Middle, Maiden Surname)

Marquerite Moore

Street WESTHILLSEY, MD 21157

31. Date filed (Month, Day,

5 ☐ Pending investigation

6 ☐ Could not be

determined

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifier

29b. Signatu

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend 23, Part II & 29a
Registrarper phy, DOR, 1/28/10, LDB

Certificate of Death

Reg No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 5:55 A Z 2010 conard /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CANDLE LIGHT COVE ASSISTED LIVING FACILITY **EASTON** TALBOT If Under 24 Hrs. Birthplace (State or Foreign Country)
 PERU 8. Date of Birth (Month, Day, Year) 3/13/1912 5. Social Security Number 6 Sex If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 X M 2 □ F 403-18-8009 97 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State items 23a or 28a-f show the Medical Exacitive rough be notified at 1 ☐ Yes 2X No Directo MARYLAND **TALBOT OXFORD** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4718 SAILORS LANE 21654 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. after Tigyes 2 No If Yes, Give Year or Dates: 1942 - 1972 Hygiene. other than "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2X No Specify: 3X Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other than any Injury or other trainmasts. **STATISTICIAN** VETERANS ADMINISTRATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALBAN FRANCIS BAYNHAM AMY MARY LLOYD-HARRIES ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4718 SAILORS LANE, OXFORD, MD 21654 MEREDITH WATTERS / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) MID SHORE CREMATION CENTER 1/22/2010 CAMBRIDGE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MID SHORE CREMATION CENTER, 2272 HUDSON RD., CAMBRIDGE, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pneumones 3 days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transi and The law requires that the death certificate be exec Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the as IF FEMALE use yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗆 No Division of Vital I∐Yes 2 ... 1 Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? A >515/4 Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 | Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated. Certifying Nurse Practitioner (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Commerce Du. Esslo. 8579

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month. Da

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		State of Maryland		artment of H			giene Reg. No. 2010	04005
Physici		1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	th Day Year	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or			19/2010 4c. County of Deat	,,,,,
Funeral Director		CHESAPEAKE WOODS CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last 1 □ M 2 7 F 94	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Da)	h 9. Birt (, Year) Co	CHESTER hplace (State or Foreign untry) SCOTLAND
Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, To MARYLAND DORCHESTER	own or Lo		AMBRIDGE			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ire Medical Ergi, Inc. rust by rediffice at once.	Funeral Director	10e. Street and Number 212 METEOR AVENUE, APT. 704 11. Marital Status 12. Was Decedent Ever in U.S.	13. \	10f. Zip Code Vas Decedent of His fYes, specify Cubar	21613		10g. Citizen of What Co SCOT 14. Race - Ame	LAND rican Indian,
hours after	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 3 ☐ No		I □Yes 2♥ No	Specify:	Hican, etc.)	Black, White Specify: 16b. Kind of Business/	WHITE
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ar yland 2 should be filed and Mental Hygi s marked other aumatic event, I	To Be	17. Father's Name (First, Middle, Last) JOCK MCLEOD 19a. Informant's Name/Relationship (Type, Print)	9h Mailin			ELIZAI	Maiden Surname) BETH MURPH' r, City or Town, State, 2	
es 1 and 2 s of Health ar of Hem 27 is rother trau		GERALD P. BOYLE / SON 20a. Method of Disposition 20b. Place	of Dispo		WINTERS C		RIDGE, MD 216 20c. Location - City or	13
Dallillor permit. Pages Department of Important: If It any injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OLD TR		HURCH CEMET. Name and Address		2/2010	CHURCH	CREEK, MD
Physician		23a. Part 1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	o not ent		g, such as cardiac			Approximate Interval Between Onset and Death
wate be executed by Sale be executed by Sician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to him odieto cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence could be consequence). C. Due to (or as a consequence could be consequence).	ce of):	N.C.(1) V = 100 C		50-130		
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Wio 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 9 □ Unknown		Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
w requires that been signed be should be deta	þ	Part II. Other significant conditions contributing to death but not resulting Colonaly Alfely Disease Hypoth		11.	nin Part I.		bacco use contribute to	
Physician: The law ruthis certificate has be rail director, page 2 should be a	Completed	Hypertension, Atrial Fibrillation, Cell Concer, Ostroagthritis Dementia	Deepl	kun thromb	asis, Squamo	24a. Was a autops perform	sy prior to death?	topsy findings available completion of cause of 2 ☑₩6
Attending Physician: It death. ector: After this certification by the funeral director.	on: To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Outpatien D. Time of Injury	Otho	4 LSH Nursing Inc	me 5 Resid	ence 6 □ Other (Spec ow injury occurred	cify)
To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stre		es 2□No	28f. Location (Si City or Town	treet and Number or Ru n, State)	ral Route Number,
the Hospitz in 24 hours the Funeral pletely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	lge, death and/or inv	occurred at the tim restigation, in my op	e, date and place, inion, death occur	and due to the d red at the time, d	cause(s) and manner as late and place, and due	stated. to the cause(s)
No To With Con.	2	29b. Signature and little of certifier.	1	29c. License	44615		29d. Date signed (Month	f, Day, Year)
Stat		30. Name and address of person who completed cause of death (Item 23a) 2	Bran	nble St	Cambo	idge,	Mary (An	<i>S</i> /
Registra	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature JANS 1 2010	A. 1	park				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0021 BENTIE LIZABETH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 M 2 F Months Days Hours Min. Country)
Maryland 75 Director 213-30-8109 Dec Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 ☐ Yes 2 🕅 No Caroline Maryland Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25465 Hill Road United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Was Deceden 2. Armed Forces?
1 ☐ Yes 2 X No Black. White, etc. δ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: Specify: 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygienα is marked other th 12 Secretary State of Marvland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ഉ James B. Hopkins Irma E. Spriggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irma E. Marshall / Daughter 25465 Hill Road, Greensboro. MD20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lincoln Crematory 1/25/2010 Brentwood, Maryland 21 Signature of Furieral Se vice like 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Appapolis. 23a. Panh. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-1 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? Pregnant at time of death 1 Yes 2 Unknown the 9 Unknown by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate ! Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes ဂ္ဂ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. injury work?
1 Yes 2 No 1 Natural 5 Pending after death.

Director: Aft d in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a 🔎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

ANNAPOLI

Name and address of person who completed cause of death (Item 23a) Type Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Janu 9814AM 2010 Lonnie Belcher, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Doctor's Community Hospital Lanham Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)

New York 8. Date of Birth 7. Age (In yrs. last birthday) Funeral 6. Sex (Month, Day, Year) 06/29/1948 Davs Hours Min. **Director** 052 36 6041 61 New Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Q Yes 2 No MD Prince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 9100 Springhill Lane #303 20770 US 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Shours be and Montal Hygiene. ģ 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give $i \neq \ell \in \ell \in \ell$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify: Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Logistics <u>Private</u> æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lonnie Belcher, Sr. Annie Crawford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes Thomas/fiancee 9100 Springhill Lane #303 Greenbelt, MD20770 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Riverdale Park Crem. 2-1-10 Riverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility BRISCOE-TONIC FUNERAL HOME MUL 902 2294 Old Washington RD Waldorf. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? signed by the atte Month Day Year 2 No 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of has autopsy severe ~ Y death? this certificate 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 300 2 ER/Outpatient 3 DOA 은 patient 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending injury 2 \square No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) m DI) 60611 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mD. Lackom. 8118 Good Luck Samue AstaumDo Kd.

DHMH 17 Rev 7/2009

State Registrar Registrar's Signature

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	yland how		10a. State	10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
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lore	permit. Pages 1 and Department of Healt Important: If item 27 any Injury or other 1 once.		20a. Method of Dis 1 Burial 2		Removal from Stat	e		sition (Name of natory or other pla	i	Date	20c. Location	•	
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מ	permit. Departr Imports any Injt		1/0) - N (2)	I mo	5/192		35 Old Wa					0601
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	vithin : Fo the comple	Mec	29b. Signature and	tile of certifier	and manner	sidieu.		29c. Licens	se number		29d. Date sign	ned (Monti	h, Day, Year)
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7	2(0)				completed cause of 04 01d Bra	,	, , , , .	Print)		Maryland	20748	,	
	Sta Registr		31. Date filed (Mor	JAN 27	32. Regis	strar's Signa	ture						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January Physician/ 19,2010 2:30 P M Thomas J. Burnett Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1249 Crowell Court Arnold Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 1 M 2 □ F Funeral CO CO Months Days Hours Min 03/13/1951 220-56-9493 58 Director Usual Residence of Decedent 28a-f shov 10a State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Anne Arundel Arnold 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1249 Crowell Court 21012 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 XMarried Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify. "natural", 3 ☐ Widowed 4 ☐ Divorced Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 01 Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Jack G. Burnett Castee1 Norma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila Burnett Spouse 1249 Crowell Court Arnold, MD 21012 1 and 2 s if Health item 27 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 01/21/2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneval Service Licenses 22. Name and Address of Facility 12 Ridgely Ave Annapolis MD 21401 Hardesty Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final Inset and Death Physician/ disease or condition Medical resulting in death) a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Vear 4 ☐ Pregnant at time of death g ☐ Unknown signed by the a d be detached f 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2XNo 3 Probably 4 Unknown has been sig je 2 should t 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No ☐ Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After Natural iniury 5 Pending 1 Yes 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner of the basis of examination was allowed by the cause of the basis of examination only one) 29b. Signature and title of certifier 29c. License numb

CA+3 State Name and address of person wh

Registrar
DHMH 17 Rev 7/2009

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completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 27,_ Dorothy Jenkins Bozman 2010 9:00 P January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1704 Old Mill Lane Salisbury Wicomico 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Days 1 □ M 2 1 F Yrs. 265-90-7279 95 Sept.22, 1914 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1704 Old Mill Lane 21801 <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify: Specify: White 3 Midowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samue1 Jenkins Lillie Hughes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda J. Waller- Niece 4510 Coulbourn Mill Foad Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/1/2010 Mattdela Springs, MD Mardela Memorial Cem. 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Ligensee 705 E Main Street, Salisbury, MD 21804 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EMENTIA Y FARS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Dav Year

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Directo

Funeral

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Completed

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Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Medical Examined in any injury or other traumatic event, the "Medical Examined in any injury or other traumatic event, the "Medical Examined in any injury or other traumatic event, the "Medical Examined in any injury or other traumatic event, the "Medical Examined in any injury or other traumatic event, the "Medical Examined in any injury or other traumatic event, the "Medical Examined in any injury or other traumatic event, the "Medical Examined in any injury or other traumatic event, the "Medical Examined in any injury or other traumatic event, the "Medical Examined in any injury or other traumatic event, the "Medical Examined in any injury or other traumatic event, the "Medical Examined in any injury or other traumatic event, the "Medical Examined in any injury or other traumatic event, the "Medical Examined in any injury or other traumatic event, the "Medical Examined in any injury or other traumatic event, the "Medical Examined in any injury or other traumatic event, the "Medical Examined in any injury or other traumatic event, the "Medical Examined in any injury or other traumatic event, the "Medical Examined in any injury or other traumatic event of the event of the any injury or other traumatic event of the ev

Baltimore, Maryland 21215-0036

Examine

The law requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

To the Hospital or Attending Physician:

death.

within 24 hours a

To the Funeral C

completely filled i

Medical

IF FEMALE:

attending physician and for use as the burial-trar signed by the a page 2 certificate After thi ours after death neral Director: / filled in by the fi Medical Certific

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Part II. Other significant condi	itions con	tributing to death but not res	ulting in the underly	ing cau	use given in Part I.		23e. Did tobacco us	se contribute to the cause of death?
OST	EOP	OROSIS					1□Yes	No 3 Probably 4 Unknown
							24a. Was an autopsy performed? 1 □Yes 2 ▼No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medic examiner?					26. Place of De	eath (Cl	heck only one)	
1 Yes 2 XAL	H	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3[DOA	Other: 4 Nursing	Home	5 Residence 6	☐ Other (Specify)
27. Manner of Death Natural 5 Penc 2 Accident inves		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	- 1	c. Injury at Work? 1 ∐Yes 2 ∐No	28d.	Describe how injury	occurred
3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	d not be rmined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, fa	ctory,	office	28f.	Location (Street and City or Town, State)	d Number or Rural Route Number,
29a. Certifier (Check only one) Continuous 2 Medic	ing Phys	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death occu ation and/or investig	ırr ed a ation, i	t the time, date and place n my opinion, death occ	ce, and curred a	due to the cause(s) at the time, date and	and manner as stated, place, and due to the cause(s)
29b. Signature and title of certif	ier			29c.	License number		29d. Date	e signed (Month, Day, Year)

State Registrar

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31. Date filed (Month, Day, Year)

SIONS

nd address of person who completed cause of death (Item 23a) (Type, Print)

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RIVERSIDE DA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2-1-2010 9:40 AM Helen Cubitt 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Northampton Manor If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Aug. 29 9. Birthplace (State or Foreign ^{Year)} 1916 Hours Min 1□ M 2□XF Months Days Mary Land 219-20-3473 93 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 1 Nes 2 No Frederick Frederick Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21701 22 Frederick Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor/ Assembley Manufacturing 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jennie A. Geisler James E. Giesler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2212 W. Greenleaf Drive, Frederick, MD William L. Mann, nephew 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery Feb. 4, 2010 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford P.A. F.H. Signalare of Funeral Service M00255 106 East Church Street Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stroke Week disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 | Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy 2 **X** No 1 ☐ Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Director

Funeral

2

Completed

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Examiner

Funeral

Director

2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show

Pages 1 and 2 s ment of Health an

permit. Pages 1 and 2 Department of Health Important: If item 27 i any injury or other tra once.

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the fledical Examinations to notified at

burial-tran as 1

and attending physician the b the cate has been signed by page 2 should be detach this certificate After t after death Director: filled in by

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

within 2

e Funeral I

completely

death.

Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 Completed 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕻 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D43091 2-1-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

House Ave

Frederica

MD 217 41

Registrar

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31. Date filed (Month, Day,

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		•	For State Registrar		State of M	arylan	•		ent of I te of L		Mental H	ygien Reg. N	001	Λ	01.012
	Physicia Medic			Jesus Ca	ampos						2. Date of D Month Jan •		, 201°	3"	3. Time of Death 1:40 p M
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	yland f show ed at	ctor	Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	y, Town or Lo	cation						100	d. Inside City Limits
	th the Mar 3a or 28a- t be notifi	Funeral Director	MD 10e. Street and Nur	mber	vert		-	10f. 2	Zip Code	ings		10g. C	Citizen of What		1 X Yes 2 □ No y?
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status	ied 2 🗆 Married	Maryland 12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates.	Ever in U.S	S. 13.		edent of H	20736 lispanic Origin? (S an, Mexican, Puer Specify: Mex)-	14. Race - A Black, W Specify:	mericar	О.
215-0	nin 72 hour ne. han "natur e M-dical	Completed	(Spe	15. Decedent's lecify only highest gooday (0-12)	Education	5+)	16a. Dece (Give life. D	kind of w		during most of wo	rking	16b.	Kind of Busine	ess Indu	stry
Maryland 21215-0036	oe filed with antal Hygien ced other to cevent, the	To Be C	12 17. Father's Name (Armando					Wa	itre	18. Mother's Na	me (First, Middle		Resta Surname)	ura	int
Mary	d 2 should I alth and Me 27 is marl r traumati		19a. Informant's Na	ame/Relationship (•					and Number or Ri aryland	ural Route Numb	er, City o			
Baltimore,	Page 1 and ment of Her ant: If item ury or othe				☐ Removal from State	С	Place of Disponentery, cremetery, cremetery	natory of	r other plac		Date / 1 0		Location - City		
Balt	permit. Departi Import any inj		21. Signature of Eu	reral Service Vicer	A .					ss of Facility R			od F.H 2075		P.A.
-	Physician/ Medical		23a. Part 1. Enter t shock, or hea Immediate Cause (disease or condition resulting in death)	rt failure. List only (Final	nplications that cause one cause on each line a	lise	r meta			g, such as cardia	c or respiratory a	urrest,		ا	Approximate Interval Between Dinset and Death
0	be executed sician and purial-transit	ical Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated event resulting in death)	nmediate rlying iinjury s	•	a consequ	docvive uence of):	med	· gwen	y of gash	n'L origin	1			5 years
. Box 68760	The law requires that the death certificate be exate has been signed by the attending physician page 2 should be detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 € 9 ☐ Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Feta	aldeath 3	Ectopi	c pregnand (spec <i>ify)</i>	Эy			23d. Date of Month		/ ay Year
ls, P.O.	uires that the dea n signed by the a ild be detached f		Part II. Other signif	ficant conditions	contributing to death b	out not res	ulting in the u	nderlyin	g cause gi	ven in Part I.					cause of death?
Division of Vital Records,	The law require ate has been si page 2 should I	Completed by									24a. Was auto per 1 \sum Yes	s an opsy formed	prior	to comp	y findings available pletion of cause of
/ital		To Be (25. Was case referred examiner?	ed to medical	Hospital:	ont 2 🗆	ER/Outpatier	+ 2 🗆	Oth	ace of Death (Che				12.1	
on of \	Attending Physist death. Sctor: After this by the funeral di	Certificate: T	27. Manner of Deatl 1 ☑ Natural 2 ☑ Accident	5 Pending Investigation	28a. Date of inju (Month, Da	iry	28b. Time of injury		28c. Injur	y at	28d. Describe			<i>Decity)</i>	
Divisi	Hospital or Atten 24 hours after deat Funeral Director: sted filled in by the	al Certif	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not lidetermined	building, et	c. (Specify)				City or To	wn, Stat			oute Number,
	To the Hospital or Attending Physician: To thin 24 hours after deactor atthin 24 hours after deactor atthin to the funeral Director. After this certific completed filled in by the funeral director,	Medical ((Check 2	Medical Exan	ysician: To the best of niner: On the basis of e rse Practioner: To the	xamination	n and/or inves	tigation, i death occ	n my opinia	on, death occurred e time, date and p	at the time, date	and plac he cause	e, and due to the	as state	ed.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 0200 AM hambers lanuary 26,2010 arion /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Chestertown River Kent Hospital (enter If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**X** M 2□ F 7, MARYLAND AUG. 1916 Director 213-03-0880 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Exeminer must be notified at Yes 2 No Director MD OUEEN ANNE'S CENTREVILLE 10g, Citizen of What Country? 10e. Street and Number 10f. Zin Code 202 BELVEDERE AVENUE 21617 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 Never Married 2 Married Yes 2 Yes, Give 3altimore, Maryland 21215-0036 1 □Yes 2 No Specify: 2 lf Yes, Give Year or Dates 1942–1943 3 X Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) OIL COMPANY PRESIDENT 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CARROLL DUNBAR CHAMBERS MARY MARGRETTA COVINGTON ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important; If item 27 is n any injury or other traum once. REBECCA JANE CROUCH/ DAUGHTER 6401 HALIFAX CT., WARRENTON, VA 20187 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) CHESTERFIELD CEMETERY 1-30-2010 CENTREVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ARREST CARDIAC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HEART Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner HYPERTENSION law requires that the death certificate be executed burial-transi Due to (or as a consequence of) attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) o cate has been signed by the page 2 should be detached 9 ☐ Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 **X** No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ➤ No 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Natural 5 Pending Hospital or Attendia to hours after death.

**Inneral Director: A sly filled in by the fu 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital
within 24 hours a
To the Funeral I
completely filled 29a, Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0066548 Kevin CARR, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Brow Registrar's Signature

State Registrar

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Year)

31. Date filed (Month)

Division of Vital Records, P.O. Box 68760,

Attending Physician: The law requires that the death certificate be executed burial-tran physician the is certificate has been signed by the director, page 2 should be detached certificate this after death Director: Hospital or within 24 hours a To the Funeral D

Funeral

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Christopher

Baltimore, Maryland 21215-0036

injury or other traumatic event, the Michael Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 amy injury or other traumatic event, the Model Examiner must be none.

Physician

/Medical

Examiner

Examiner

Completed

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Certification: To

Medical

State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robins William M.D. 200 C

31. Date filed (Month, Day, Year) 32. Registrar's Signature

			For State Registrar	State of I	Maryland / Dep <i>Ce</i>	artment of H ertificate of L		-	giene Reg. No. 20	110	04015
	Physici	an	1. Decedent's Name (First, Middle, Las	,				2. Date of Dea Month	Day	Year	3. Time of Death 9:00 P M
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	Examir	ıer	Wicomico Nursi			Salis				comic	О
	Funeral Director		5. Social Security Number 6. S		Age (In yrs. last birthday 76 Yrs.			24 Hrs. 8. Date of Birt (Month, Da 04-06-	h y, Year) 1933	9. Birthpla County Mary	ace (State or Foreign ry) Land
	put w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10	d. Inside City Limits
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	r 28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	ry?
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	be filed within 72 hours after death with the Maryland Hygiene. id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decede Armed Force 1 ☐ Yes 2		Was Decedent of H If Yes, specify Cuba	ispanic Ori an, Mexicar	gin? (Specify Yes or No n, Puerto Rican, etc.)	. 14. Rad Bla	ce - America ck, White, e	
36	urs aft	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Date		1 ☐ Yes 2 No	Specify:		Specif	^{y:} Whit	ie
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ore	iges 1 ar nt of Hea if item or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		ale	osition (Name of ematory or other place	1		20c. Location		
Baltimore,	permit. Pages Department of t Important: If ite any injury or of	١,	4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lices			Cemetery 22. Name and Addres Inman Fund		01/23/2010	Fruitla:	nd, Ma	ıryland
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Division	To the Hospital or Attenc within 24 hours after death To the Funeral Director; completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not b	Zoe. Place o	finjury - At home, farm, s , etc. <i>(Specify)</i>	street, factory, office		28f. Location (City or To	Street and Num wn, State)	ber or Rural	l Route Number,
Ω	Hospital or 24 hours afte Funeral Dir tely filled in I		29a, Certifier 1 ertifying P	hysician: To the h	est of my knowledge, de	ath occurred at the ti	me date a	nd place, and due to the	cause(s) and m	nanner as st	ated
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/	3		30. Name and address of person who		, , , , , ,	•	. C = 7	dahama MD	01904	1	
	St	ate	Mahesha Thimmaray 31. Date filed (Month, Day, Year)	32. Re	strar's Signature		c sal	isbury MD 2	21004		
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DHMH 17 Rev 1/2001

DIVISION	To the Hospital or Attending	within 24 hours after death.	To the Funeral Director: Afte
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		State Registrar		Cei	rtificate of I	Death		g. No. 4 U (1 14016
Physicia		1. Decedent's Name (First, Middle, Last) Dorothy V. Chambers					2. Date of Death Month January	Day Year	3. Time of Death 3:10 P M
/Medic		4a. Facility Name (If not institution, give street and numb	per)		4b. City, Town, or	r Location of Death		4c. County of Dea	
- LAGIIIII	•	Anne Arundel Medical	Cente	r	Annap	olis		Anne A	rundel
Funeral			Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) C	thplace (State or Foreign ountry)
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death ms 2	Funeral	11. Marital Status 12. Was Decede		S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Am	
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ours	d by	3 Widowed 4 Divorced Year or Date	es:						lack
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al Hyg othe vent,	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Name			10 1100 p 1 0 0 1
Ments Ments arked atic e	2	James H. Chambers Sr					e E. Jo		
2 shoth and hand is more reaum		19a. Informant's Name/Relationship (Type. Print)			,			City or Town, State,	
1 and Health em 27 ther t	-	Margaret E. Nick (Day 20a. Method of Disposition			Stephan Stephan Sition (Name of			is, Md.	
ages int of l t: If ite		Nation 2 ☐ Cremation 3 ☐ Removal from St		emetery, crer	matory or other place Mem. F	ce) !		nnapolis	
nit. Partme artme ortan injury	}	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee			2. Name and Addre	1			
permi Depa Impo any it		Javy B. Reen Mc	0487	82	Wm. Res	se & So St. Ann	ns Mort	uary, P Md. 214	ði
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e iii		resulting in death) Last Due to (or	as a consequ	uence of):					
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tendi feath. tor: A	cati	2 Accident investigation				lYes 2 □No	206		David March 1
after o	Certification: To	4 Homicide determined 28e. Place of building	, etc. <i>(Specif</i>)	me, tarm, str y)	eet, factory, office		City or Town,	eet and Number or F State)	nurai Houte Number,
ospita hours ineral y filled		29a. Certifier 1 Certifying Physician: To the b							
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only 2 Medical Examiner: On the bas and manne		tion and/or in					
No To Con	2	29b. Signature and title of certifler			29c. Licens		29	Od. Date signed (Mor	
RH	-		of death (Item	23a) (Type		1904			
3		30. Name and address of person who completed cause Rcbait Peterson M 31. Date filed (Month, Day, Year) JAN 2.2 2010 32. Rg	> qualif (fiell	AA	mc,	tunepol	y shis	2140	1
Stat		31. Date filed (Month, Day, Year) 32. Re	jistrar's Signa	ture	6.41	U			
Registra	ar	JAN 2 2 2010 🚜	neva	1. 14	Barre				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Paul S. Cohen 1/16/2010 0500 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Arnold Anne Arundel 751 Match Point Dr. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign **Funeral** Months Hours Min. (Month, Day, Year, 9/30/192 1 **X M** 2 □ F Director 216-22-2997 82 MD Usual Residence of Decedent important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XX No Arnold MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21012 USA 751 Match Point Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No WWII
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2XXNo Specify: 3 XXVidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Retail 0wner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Ments Important: If item 27 is marked Yetta Reichel Jacob Cohen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arnold, MD 21012 751 Match Point Dr. Judy Gettier Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Tremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/22/2010 Glen Burnie, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service License Tall Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. iterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sician and burial-transit that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death signed by the a d be detached f Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Ünknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed2 certificate 2 🗌 No ☐ Yes 1 🗌 Yes 2 N Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Magmer of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 \square Pending Natural n 24 hours after death.

• Funeral Director: After the function by the function of the functin 2 Accident
3 Suicide 1 🗌 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Fertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. з 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 28686 completed cause of death (Item 23a) (Type, Print) CHACQNAS M.D

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month

Box 68760

P.O.

Records,

of Vital

Division

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month William 12:05AM Cauffman Janua 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct.16, 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 XXM 2 - F Hours Maryland Director Yrs. 220-16-1249 82 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Washington <u>Hagerstown</u> 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 77 Nottingham Road 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2XXMarried þ 1XX/es 2 □ No 1945-If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: "natural", Completed 3 Divorced 4 Divorced Specify: 1947 Year or Dates White Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nould he filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Supervisor Soda Bottling Company other traumatia event, Be 17. Father's Name (First, Middle, Last) of Health and Mental History is and Mental History is marked off 18. Mother's Name (First, Middle, Maiden Surname) ၉ Arthur Cleveland Cauffman Jennie Elizabeth Nagle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary V. Cauffman-Wife Nottingham Road Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite any injury or ot cemetery, crematory or other place) XX Burial 2 Cremation 3 Removal from State 4 Domation 5 Other/Specify Cedar Lawn Mem. Park Jan.29,2010 Hagerstown, Maryland Osborned Funeral Home, P.A. 21. Signature of Funeral Ser 425 S. Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine attending physician and for use as the burial-transit that the death certificate be executed Due to as a consequence of resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year 1 Yes 2 9 Unknown 9 Unknown Records, P.O. signed by t d be detach 23e. Did tobaccouse contribute to the cause of death? <u>ک</u> Completed 1 LYes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has Hospital or Attending Physician: The I 24 hours after death.
 Funeral Director: After this certificate h performed 2 🗌 No Yes 2 No 1 🗌 Yes **Division of Vital** Be 25. Was case referred to predical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 5 Pending 1 Tes 2 No 2 Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

State Registrar

13H5+1

DHMH 17 Rev 7/2009

NIL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SINE

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State
Registra MENDED PER EH 1/29/11 Certificate of Death AJS CCHD Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 4:38A M 2010 January Katherine Nancy Cramer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline Denton Caroline Home for Hospice If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Funeral Year Hours 1 □ M 2 🖾 F 10, 96 1913 Director July 136-20-2707 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Modical Exercities must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Caroline Denton 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. Completed by Funeral 1231 Fairfield Court 21629 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withii nent of Health and Mental Hygiene. Waitress Restaurants 7 is marked other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jennie DeCaeser Benjamin Paone ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ¹⁹a Informant's Name/Belationship (Tyge, Print) Josephine Kidwell/daughter permit. Pages 1 and 2 s
Department of Health au
Important: If item 27 is
any injury or other trau 21629 Joseph Kidwell/Son 1231 Fairfield Court, Denton, Maryland 20b. Place of Disposition (Name of cemetary, crematory or other place)
Huff & Lakjer
Funeral Home, Inc. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 Toremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lansdale, Pennsylvania 1/21/2010 22. Name and Address of Facility 21. Signature of Funeral Service License Fleegle and Helfenbein Funeral Home, PA 106 W. Sunset Ave., Greensboro, Maryland 21639 Approximate Interval Between Onset and Death 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, basin grown mechale cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Que to for as a nonscialinno of) Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d, Date of delivery 3 Ectopic pregnancy Month Yea Day 5 ☐ Other (specify) P.O. ned by the a 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b irector, page 2 s autopsy performe 1 ☐Yes 2 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6X Other (Specify) HOSPICE Certification: To 27. Manner of Jeath 28a. Date of Injury (Month, Day, Year) 28d Describe how injury occurred 28b. Time of 28c. Injury at Work? Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title D63063 erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of LANE DENTON MARYLAND 21629

Registrar

State

31. Date filed (Month, Day,

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month j Physician/ Pay ZUTO 1130 M Gary Bon Clayburne Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SDLISBURN HICAMI CO If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In vrs. last birthday) 8. Date of Birth Funeral 1**X** M 2 □ F Days Hours Min 0510811961 Washington, DC 219-21-7143 48 Director Usual Residence of Decedent show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c City Town or Location 10d. Inside City Limits Director 1 XYes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 614 S. Westover Drive 21801 USA within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White etc. should be filed within 72 hours after d and Mental Hygiene. is marked other than "natural", or i 9 1 X Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify. black 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 construction carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) t. Page 1 and 2 should be fill thrent of Health and Mental tant: If item 27 is marked or unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1522 Sharen Dr., Salisbury, MD 21804 Nicole Collins friend permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 X Donation 5 Other (Specify) Anatomy Gifts Registry 1 | 25 | 10 Hanover, MD Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Licensee Kello Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 🗌 No 3 Probably Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? has autopsy perform this certificate 1 ☐ Yes 2 ☐ No Physician: completed filled in by the funeral director, 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 X No မ 1XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) · After t 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: or Attending Natural 5 Pending work? 1 ☐ Yes Division To the Hospital or Attendir within 24 hours after death. To the Funeral Director; Af 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) y JAN 25, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

State

BAIG MD

31. Date filed (Month

32. Registrar's Signature

SAlisbury md 21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 21, Day 2010 Michael Joseph Downey 8:50 a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 11117 Stillwater Avenue Kensington Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) D. C. **Funeral** Hours Min Nov. 17ay, 1925 577-40-1284 Director 84 Usual Residence of Decedent show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits Maryland Montgomery Kensington 1 ☐ Yes 2 🖰 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11117 Stillwater Avenue 20895 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No WWII White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Specialty Advertising Business Owner Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Michael Joseph Downey, I Adelia Joan Burdine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11117 Stillwater Avenue, Kensington, MD 20895 Phyllis F. Downey/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jan. 26, 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licenses 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Coronary Artery Disease Medical Due to (or as a consequence of) **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit Hyperlipidemia Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Completed been si 24a. Was an 24b. Were autopsy findings available his certificate has b il director, page 2 sl autopsy prior to completion of cause of death? performed?

Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 2 🙀 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 A Residence 6 Other (Specify) eral Director: After this filled in by the funeral di Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d

To the Funeral Direct

completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Burse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 1+1 D35370 January 22, 2010 d cause of death (Item 23a) (Type, Print) 30. Name and addre 11126 Rockville Pike, Rockville, MD 20852 Bachowski, MI Jan 31. Date State 2010 5 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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arrott	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	nat Coun	try?
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 24. 2010 9:45 A M Jan. Leona Pumphrey Darley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FutureCare Chesapeake Anne Arundel Arnold If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 ☐ M 2 🖾 F 104 212-52-4514 Director 08,1905 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City. Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Exaction must be putilized at 10d. Inside City Limits MD Anne Arundel Severna Park Director 1 ☐Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 426 Arundel Beach Road 21146 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐Yes 2X No à Specify: Specify: 3 XWidowed 4 ☐ Divorced Health and Mental Hygiene. em 27 is marked other than "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Court Stenographer Annapolis 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ould be f William John Pumphrey Laura E. Stone Pages 1 and 2 should I ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If item 27 is any Injury or other traionce. Ralph E. Darley / Son 426 Arundel Beach Road Severna Park, MD 21146 Date 28, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Jan. Woodlawn Cemetery Baltimore, MD 2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** dvanco disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, ner if any, he in the immunication of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physiclan: The law requires that the death certificate be executed Exami attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnan 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 mon Month Day Year 5 Other (specify) the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an performe certificate 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of After 28d. Describe how injury occurred 1 W Natural 5 Pending investigation after death Director: / 2 Accident 1 ☐ Yes 2 🗆 No 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

Division of Vital Records, P.O. Box 68760 24 hours af E Funeral Di letely filled in

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 40 DM January Daily Glenn Α. 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner Fahrney-Keedy Home & Village Boonsboro Washington 8. Date of Birth (Month, Day, Year)

Jan 10, 1911 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1**∑** M 2□ F 176-09-1741 99 Director Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedled Examinat must be notified at once. Director 1 ☐ Yes 2 🛛 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1856 Meridian Drive Funeral 21742 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2**X**☐No 2 Specify Specify: 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Manufacturing Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George L. Daily ပ Minnie F. Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gene L. Daily / Son 1856 Meridian Drive Hagerstown, Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Peter's Cemetery 01/30/2010 Canal Township, PA 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 21. Signature of Funeral Service Licensee 7606 Old National Pike Boonsboro, MD 21713 23a. Part 1 Enter the disease, or complications that or used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** meu maria disease or condition resulting in death) /Medical Lue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) signed by the a d be detached f 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown After this certificate has been s funeral director, page 2 should it Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 1∐Yes 2∐No 2 **X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide

Division of Vital Records, P.O. Box 68760,

Ball

Alenn

Saltimore, Maryland 21215-0036

State Registrar

Medical npletely

29a, Certifier

(Check only one)

29b. Signature and title of certifier

Khalid M. Waseem 1126 Opal Court Hagerstown, Maryland 21742 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20

JAN 27

32. Registrar's Signature

Recritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

052323

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 4:00 AM a7-2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5. Social Security Number Worcester Nursing Home

X Dage (In yrs. last birthday) Foomote City Hall Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1**⊠**M 2□ F 9 Director 579-52-7773 - 1916 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 Nes 2 No Salisbury Director Wicomico mD 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code 21804 Way Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 19 3 14 16 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.

Is marked other than "natural", or ite 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specity. Specify: White 3 ☐ Widowed 4 ☐ Divorced 1934-1960 15. Decedent's Education (Specity only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Şecondary (0-12) College (1-4or 5+) Officer 12 permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, Important: If item 27 is marken any Injury or contact. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bessie Brasure ပ Sidnel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Salisbury no als Way Winding Daisey 21804 Uneida Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Chincoteague 4 ☐ Donation 5 ☐ Other (Specity) Greenwood 1-29-2010 Cemetery Chincoteague, NA 23336 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Botto 6327 Church Funeral Home, dnc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DEMENTIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** ASPIRATION PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specity) Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specity) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 1) 0062172 1 27 2010

£.T 15+1 State

DHMH 17 Rev 1/2001

Registrar

1604 MARKET ST POCOMOKE CITY MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, MD

Registrar's Signatur

SATYAL

2010

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SHARAD

31. Date filed (Month L

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Loretta Delurey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 110% No Regional Medical Cente 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 083-28-6460 1 🗆 M 2 🛛 F Months Min 0110611936 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Maryland Berlin Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 35 Westfield Circle 21811 USA 12. Was Decedent Ever in U.S Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 secretary education Be other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil Department of Health and Mental Important: If item 27 is marked of မ Elsie Helwig Edward Hogan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Delurey spouse 35 Westfield Circle, Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Tsland National injury or $\mathsf{Lon}^{c}_{\mathsf{q}}$ 01 28 2010 Pinelawn, NY 4 ☐ Donation 5 ☐ Other (Specify) Cemetery any inj once. Holloway Funeral Home Professional association dompor 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Due to (or as I consequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Exami attending physician and for use as the burial-transil Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death n signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown page 2 should obes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an diseas Jas performed? Yes 2 No 24 hours after death.

Funeral Director: After this certificate hated filled in by the funeral director, page or Attending Physician: 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital 2 No Other: ည 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital o within 24 hours af To the Funeral Di 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

1 ☐ Yes 2 ☐ No

Year

1 X Yes 2 No

New York

0454A M

Registrar DHMH 17 Rev 7/2009 SALISBURY MQ. 21801

100€

MD

31. Date filed (Month, Day, Year)

CARROLL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea, No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Eileen Deehan 400 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death JICOMIC along Social Security Numbe If Under 1 Year Funeral If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🗆 M 2 🕱 F 02 24 11932 New York 099-26-2750 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 1101 S. Schumaker Dr., Apt. 8 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Completed white 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) food secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Bernard J. Carney Elizabeth M. Cunningham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 1101 S. Schumaker Dr., Apt. 8, Salisbury, MD 21804 James Deehan spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1 26 10 Salisbury Crematory Salisbury, MD 21. Signature of Funeral Service License 2476715WayesFuerWal Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ neumonia Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin and I-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 N 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? 2 🗹 No Other: ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 032212 1-23-2010

State Registrar SHIPHIN

104 MI 1410

SALISBUM MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

M.O.

gegistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 04028 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mary Eloise Ennis 848 M TAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death licom along 1 If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Country) Age (In vrs. last birthday) **Funeral** 6 72 5 7 Y 92 5 1 🗆 M 2 🔀 F '8Ó Months Days Hours Min 218-24-5965 VA Yrs Director Usual Residence of Deceder 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Tes 2 X No MD Wicomico Salisbury 10e. Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? 23a875 Victoria Park Apt. 120 21802 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 þ Yes 2 No Yes, Give 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify "natural", 3 ☐ Widowed 4 ☐ Divorced Specify: Completed white Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) the Bookkeeper Automotive traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Douglas Wimbrow Mary Ennis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Julie Johnson/ daughter 30905 Ward Rd., Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 5 1 XBurial 2 Cremation 3 Removal from State Department of Important: If any injury or once. Bates Cemetery 2/3/2010 4 ☐ Donation 5 ☐ Other (Specify) Snow Hill, MD 21. Signature of Funeral Service Li 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Vear the 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform yes 2 No in 24 hours after occur.
The Funeral Director: After this certificate maleted filled in by the funeral director, pe 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Yes 2 No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1.XNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 34593 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAlisbury md 21801 MD 31. Date filed (Month, Day, Yeal) 32. Registrar's Signature State FEB Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

		 State Registrar 					Cer	tificate	of L	Death			Reg. No		0	0.1	000
Di	,	1. Decedent's Name (First,	Middle, La	ast)								2. Date of Dea	ath	201	U	3. Time of	Death
Physician. Medica		James	Wil	liam	Eng	glish	ı					January	2 ^{Da}	, 2010 ^{ea}	r	10:15	5 A M
Examine		4a. Facility Name (if not inst	-		nber)					r Location o				. County of De			
		St. Mary's		pital						dtown				St. Mar			
Funeral		5. Social Security Number 579–46–2755		Sex 1.207 M 2.□F	7. Age (/	,	t birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt		. (Count	ace (State o. y)	_
Director	ŀ	Usual Residence of Decede		Λ		72	113.					09/06/	193	/ Wa	ısh	ingtor	L.DC
at at	- 1	10a. State 10b. C			1	0c. City,	Town or Loc	cation							10	d. Inside Cit	y Limits
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the N or 2	5	10e. Street and Number		- , -				10f. Zip 0		-		···	10g. Citizen of What Country?				
leath with the Maryland items 23a or 28a-f she er must be notified at	eLa	21412 Gre	eat M	ills Roa	ad				20	653				U.S.A.	,		
s after death with the Maryland ral", or items 23a or 28a-f show Examiner must be notified at	<u> </u>	11. Marital Status		12. Was Dece Armed Fo		r in U.S.	13. V	Vas Deceder Yes, specif	nt of H	lispanic Orig	gin? (Spe	cify Yes or No-		14. Race - Ar			
amir	2	1 Never Married 2		1 X Yes	2 🗌 No			Yes 2			i, ruerto	riidari, etc.)		Black, Wh			
tural al Ex		3 Widowed 4 Div		Year or Da	ates. 19		9							Specify: 1	whi	Le	
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hould Nama sund N	1	19a. Informant's Name/Rela	ationship (Type, Print)			19b. Mailin	g Address (Street	and Numbe	er or Rura	i Route Number	; City or	Town, State,	Zip Ci	ode)	
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of Herrican		20a. Method of Disposition 1 ☐ Burial 2 🎛 Crem	o [7.0				sition (Name		ce)		Date	20c. Lo	ocation - City	or Tov	vn, State	
Page ment ant: I ury o		4 Donation 5 0			State						01/	29/10	Alex	xandria	ı,	VA	
permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Jonce.		21 Signature of Funeral Se	rvice Lider	V.			22	. Name and	Addres	ss of Facilit	y Rau	sch Fun	era	l Home,	P	.A.	
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Physician,		Immediate Cause (Final disease or condition		, C	cuo	lia.	geni	د ح	sh	ock					i .	Onset and D	eath 5
Medical Examiner	-	resulting in death)	•	Due to	(or as a c	onsequ (1								, 24	41
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certificate: To Be Completed by Physician/Medical Exam	5		·	d A	cut	te	Ren	nul	f	-cei	Im	د ے				109	75
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he Hospita in 24 hours he Funeral ipleted filled		29a. Certifier 1 Cert	tifying Phy	sician: To the b	est of my	knowled	ge, death o	ccured at th	e time	, date and p	olace, and	d due to the cau	ıse(s) an	d manner as s	tated		
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To t		29b. Signature and title of c	ertifier	<u> </u>						e number	2	:	29d. Dat	, , ,			
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6+1		30. Name and address of pe	H.	0 1	se of deat				Dri	ve, L	eona	rdtown,	MD	20650			
State Registrar		31. Date filed (Month, Day, Y	EB -	-1 2010	egistraris	Signature	. B.	Sau	Carl de	9							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Registrar
DHMH 17 Rev 1/2001

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State

31. Date filed (Month, Day,

5. Main St Hampskad

s of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2-4-2010 Bay Lillie V. Esworthy 5:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Citizens Care and Rehab Center Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 □ M 2X F Months Days Hours Min. 217-28-5131 76 4-4-1933 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6132 Quinn Orchard Road 21704 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 21 No δ Specify: Specify: 3 → Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Austin Oden 2 Sara Hudson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Haislip 8216 Lookout Lane Frederick, Maryland 21701 Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 2-4-2010 Smithsburg, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Facility Keeney & Basford P.A. F.H. 106 East Church Street Frederick, MD 21701 M01176 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Due to or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 □Yes 1 ☐ Yes 2 ☐ No 2 NO Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Box 68760. attending physician for use as the buris P.0. the is certificate has been signed director, page 2 should be det Division of Vital Records, this 24 hours after deat Funeral Director:

detached filled in by the funeral

Funeral

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show

7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, I'm Medical Evancinat or unit by confined at

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12 should be filed w h and Mental Hygie 7 is marked other ti

permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked c any injury or other traumatic most

Physician

/Medical

Baltimore, Maryland 21215-0036

28a. Date of Injury (Month, Day, Year) 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of contifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TOLL HOUSE, FREDERICK, MD

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32. Registrar's S

State Registrar

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

Second S		P	Please Type or Prin				•	•	
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Social Security Number Social Security Num				<u> </u>	4b. City, Town, or	Location of Death			
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Doubling State Doctory	_		1 ∑ M 2□ F	Yrs.	11 011001 1 1001		(Month, Day, Ye	ar) C	ountry)
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Section Part Comparison Control Cont	23a or	Ferny Landin	ng Road		20754			SΔ	
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Coperation Cop	1 and Healtl em 27		ert E. Ford - Broth	er 67 20b. Place of Disp	'07 Wilburn osition (Name of	Drive, Capi	tol Heights,	MD 20743 Location - City of	r Town, State
28. Name and Address of Facility 29. Na	Pages lent of nt: If It ry or o	1 Surial 2 ☐ Crema					00 0040 D		
1451 Dares Beach Rd., Prince Froderick, MiD 20678 Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final resulting in death) Immediate Cause (Final Result	rmit. I spartm portai y inju			Cooper's U	M Church Cem 2. Name and Addres	ss of Facility			
Shock, or heart failure. List only one cause on each line. Physician Modical Examiner Modical Examine	9 9 E 6 9	Blady	. a. Sewelf			Beach Rd.,	Prince Frede	erick, MD 20	
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FFEMALE: 23c. If yes, outcome of pregnancy 1	d) (0 <u></u>		Due to (or as	a consequence of):					
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The state of the s	or Atte		letermined 286. Place of In	ury - At home, farm, st c. (Specify)	treet, factory, office				Rural Route Number,
Programment of the cause of the control of the cause of t	spital	29a. Certifier 1 Ce	rtifying Physician: To the best	of my knowledge, dea	th occurred at the ti	me, date and place	e, and due to the caus	se(s) and manner	as stated.
29b. Signature and title of certifier 29c. License number 46046 29d. Date signed (Month, Day, Year) 1 23/2010	the Ho lin 24 h the Fur apletely	one)	and manner st		nvestigation, in my o	pinion, death occu			
	To To To M	29b. Signature and title of o	ertifier Alex	elian				Date signed (Mor	12010
RN 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMIR ALIKHANI (OI CENTENMALST., LePKIS, MO	RW 2	A 34 . O			Print) CEX	MOTH	IALST.	, LaPl	KISIMO
State 31. Date filed (Month, Day, Year) 32. Registrate Signature	State Registrar		EEST O O ODION	Rnews 8	Sparkal			,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Year JOHN DEXTER FISHER 1858 M Januar DENT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbet Easton Memorial Hospita 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🗶 M 2 🗆 F Months Days Hours APRIL 3, 1947 005-46-3790 NEW HAMPSHIRE Director 62 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health well bylighed. Important: If time ZT is marked other than "naturali", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1X Yes 2 No QUEEN ANNE'S CENTREVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21617 USA 208 OVERTURE WAY Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ☐ Yes 2 X No 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: 3 Divorced 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ELECTRICAL ENGINEER DEPT. OF THE NAVY 1 and 2 should be filed w if Health and Mental Hygi item 27 is marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 VIRGINIA DREW JOHN A. FISHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 OVERTURE WAY, CENTREVILLE, MD 21617 JUDY KAY FISHER/ WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State CHESTERFIELD CEMETERY 1-27-2010 CENTREVILLE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. shock, or heart failure. List only Immediate Cause (Final ARREST Onset and Death ASYSTOLIC CARDIAC Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Probable Myocardial Infarction Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Physician/Medical Examiner signed by the attending physician and d be detached for use as the burial-transi Cause (Disease or linjury SINIER that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? this certificate has page 2 1 Yes 2 No Division of Vital completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 MInpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation To the Hospital or Attend within 24 hours after deatl To the Funeral Director... 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 219 S. WASHINGTON ST., EASTON, MD 21601

D0059487

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JOHN BOTSIS, M.D.,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CHARLES JAN 18 2010 11:46 P [™] FOX Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY 5. Social Security Number 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year) AUG • 9 • 1 Days 1**X** M 2 □ F Months Hours Min. WASH Director 219-42-3677 6.5 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD PRINCE GEORGES HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3615 HAMILTON ST. 20782 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 ☐ Married ☐ Yes 2 XNo 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Completed 3 Widowed 4 Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72. th and Mental Hygiene. ?7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12 OWNER REAL ESTATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **JAMES** FULTON injury or other traumatic FOX RUTH GARY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau JAMES FOX/BROTHER BOX 1330, BELLINGHAM, WA. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State CHAMBERS CREMATORY 4 Donation 5 Other (Specify) 1-27-2010 RIVERDALE, MD. 21. Signature of Funeral Service Lightness Name and Address of Facility
AMBERS FUNERAL HOME & CREMATORIUM, P.A.
601 CLEVELAND AVE., RIVERDALE, MD. 20737 M00091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Anteny Piscase Immediate Cause (Final Physician/ 1therosclerotic Cotohan disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Electrol eran Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of hemia Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant a Pregnant at time of death 5 Other (specify) Month Day Year signed by the a 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 2 🗌 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 🗌 Yes 2 🗆 No Accident Investigation Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b, Signature and title of certifie 29d, Date signed (Month, Day, Year) 52326 Z0/0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMES K. LIGHTFOOT, 7600 M.D. CARROLL AVE., TAKOMA PARK, MD. 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Helen Louise Fitzpatrick Januaru Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sanctuary at Holy Cross Burtonsville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 X F Country) New York 0Y975371975 Director 95 059-03-3279 Usual Residence of Decedent . Hygiene. other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location Director Silver Spring Maruland Montaomeru 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2320 Countryside Drive 20905 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 🗓 No þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced Completed injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Own Home is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ Edmond Schneider Elizabeth Becker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or Attack 2320 Countryside Drive, Silver Spring, MD 20905 Richard Fitzpatrick - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 01/25/2010 Silver Spring, MD Gate of Heaven Cem. 21. Signature of Fureral Semice Licen 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) evere Medical Due to (or as a consequence of) Examiner 5 80 14 Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): that initiated events Due to (or as a consequence of): resulting in death) Last physician a s the burial-1 Physician/Medical Box 68760 attending physical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 9 Unknown a I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed' 1 🗌 Yes 🔎 No Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Division of Vital funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗆 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director; Ai completed filled in by the fu 2 Accident 3 Suicide 4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the litrie, gate and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2.

3. Time of Death

10d. Inside City Limits

White

Interval Between Onset and Death

Dav

29d. Date signed (Month, Day, Year)

Year

1 Yes 2 No

5:30 am

State Registrar

29b. Signature and title of certifier

Sunitha Bhog

31. Date filed (Month, Day, Year)

JAN 25 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

29c. License number

Avnu

00054566

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 31, 2010 2:00 Рм January Abraham_Lincoln Ferguson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Garrett Oakland Nursing & Rehab Center Oakland 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2 □ F Months Days 10/01/1926 **Director** 171-16-5959 83 Usual Residence of Decedent the Maryland 10h County 10c. City, Town or Location 10d. Inside City Limits 10a State ns 23a or 28a-f show 1 ☐ Yes 2 ☑ No **Funeral Director** McHenry MD Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with United States 21541 Rt. 2, Box 109 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 if Heath and Mental Hygiene.
Item 27 is marked other than "natural", or
other traumatic event, the "Medical Exami 1 □Yes 2X No If Yes, Give Year or Dates: Specify. Specify: ₫. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Flossie Gustivia Fearer 2 Giddeon John Ferguson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 371 Pysell Road, McHenry, MD 21541 Raymond A. Ferguson, Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Itel
any injury or otl
once. Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Grove Church Cemetery McHenry, MD Name and Address of Facility
 David A. Burdock Funeral Home, P.A.
 21 N. Second St., Oakland, MD 21550 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each lip. Do not unter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1000 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ☐ No Month Day Vear 5 ☐ Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 1∐Yes 2∭ZNo 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) o the Hospital or Attending Prithin 24 hours after death.
o the Funeral Director: After it ompletely filled in by the funeral 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one)

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certific

Richard Porter

311 N. Fourth Street, Suite 1, Oakland, MD 21550 Registrar's Signature

29c. License number

H0064705

29d, Date signed (Month, Day, Year)

20/0

Please Type or Print in Black Indelible Ink Figure All Copies Are Logible

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auma		19a. Informant's Na					19b. Mail	ing Addre	ss (Street	and Numb	ber or Rur	al Route Nu	mber, Ci	ty or Town,	State, Zip	Code)	
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funeral director, page		25. Was case referre examiner?	ed to medical							26. Place	e of Death	(Check on					
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Certification T		3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	a Zoe. Flace	of Inju	ry - At home : (Specify)	e, farm, sti	eet, facto				28f. Location City or	(Street Town, St	and Numb ate)	er or Rura	I Route Nu	mber,
mpletely filled		29a. Certifier (Check only one)	Certifying i	Physician: To the aminer: On the band man	asis or	examinatio	edge, deal n and/or ir	h occurre vestigation	d at the tin	ne, date ar pinion, dea	nd place, ath occurr	and due to ted at the tin	he cause ne, date a	e(s) and ma and place, a	anner as s and due to	tated. the cause	(s)
_ d		29b. Signature and ti	itia of Pertifier	2174 1714111				- 0	c License	number.			00.1.1	Date signed			

Division of Vital Records, P.O. Box 68760, To the within To the

WJL 3

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. Raman B. Kaneve, 345 Malcalm duke,

31. Date filed (Month, Day, Year)

32. Registrar's Signature

29c. License number D - 00 54 2 (8

29d. Date signed (*Month, Day, Year*) 0|-20-20|0

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 2010 Theresa M_{\bullet} Green 11:40 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 1605 Cavalier Court Dunkirk Calvert 7. Age (In yrs. last birthday) **87** Yrs If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Jan 7. 1923 579-18-2449 Maryland Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location hours after death with the Maryland 10d. Inside City Limits Director MD Prince George's Clinton 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 8600 Mike Shapiro Drive 20735 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? 1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 √ No Specify: Specify: 3 K Widowed 4 ☐ Divorced Completed I Hygiene. other than "natura vent, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) within 72 Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Briguglio Vincenzo Carbone Giulia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Blevins (daughter) 1605 Cavalier Court Dunkirk, MD Department of Health Important: If item 21 any injury or other to once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🙀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan 28 Maryland Veterans Cheltenham. MD 21. Signature Funeral Service Licenses 22. Name and Address of Facility $8\overline{125}$ Southern Maryland Blvd Gary J. Goff Owings, MD 20736 Lee Funeral Home Calvert. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ nome disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 the IF FEMALE: sate has been signed by the attending page 2 should be detached for use 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy 5 Other (specify) in the past 12 months? 1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical of Vital director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes မှ 1 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Division 24 hours after death. Funeral Director: A 1 \square Yes 2 No 2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier completed (Check within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b Signature and title of certifier 29d. Date signed (Month. Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 2

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20่ำไื้0 January 10:01 AM Lena Kate Grogg Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Ceci1 Laurelwood Care Center E1kton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 □ M 2 🗶 F **Director** Virginia <u> 221–10–9761</u> 88 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo YXX Yes 2 No Maryland | Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 100 Laurel Drive 21921 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2XXNo Specify. If Yes Give White Specify: 3 ♥ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sylvester Halsey Julia Halsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Simmons / Granddaughter P.O. Box 29, Childs, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place).
Holly Hall Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State February Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee 1, 2010 Baltimore, Maryland 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Acute Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No ☐ Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of contifier 29d. Date signed (Month, Day, Year) Sachder-S. MD

State Registrar 31. Date filed (Month, Day, Year)

S. S Sachder MD, 126 A, E thinh St, Elkin MD 21921

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Martha January Gatling ^D2^y4 20°1°0 1845 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center <u> Annapolis</u> Arunde] Funeral Social Security Number 6. Sex Age (In yrs. last birthday) 9 4 vre If Under 24 Hrs 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign Hours 1 M 2 X F Country) 115 03 1435 Director 4 1915 Carolina June Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at filed within 72 hours after death with the Maryland al Hygiene. ad the than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Prince George MD Bowie 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5005 Health Center Drive Funeral 20716 US Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 XNo Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Unknown <u>Factory Worker</u> <u>Goodies Barretts</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental H is marked of Jim Gatling (unknown) Carteen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20721 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Velma Miller/niece 11910 St. Francis Way Mitchellville, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Donation 5 Removal from State Greenlawn Mem. Gar 2-1-2010 Chesapeake, VA 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility Corprew Funeral Home 1822 Portsmouth Blvd Portsmouth, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause an ach line. dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 month Month Year Day Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown P.O. ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has I page 2 s autopsy performed? certificate Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA
28a. Date of injury
(Month, Day, Year)
28b. Time of injury
128c. Time of injury မ this After this funeral of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred ivatural 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 ☐ Yes 2 ☐ No hours after death 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

State Registrar 30. Name

ress of person who comp

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eted cause of death (Item 23a) (Type, Print

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month DONALD COOPER GROVE 3:20 PM Medical ANUARY 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 28110 OAKLAND CIRCLE TALBOT EASTON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days Months Hours Min. Director 215-44-2531 100 06-04-1909 MARYT.AND Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD TALBOT EASTON 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 28110 OAKLAND CIRCLE 21601 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. 3 ₩Widowed 4 Divorced WHITE Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 DIRECTOR PHARMACEUTICALS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. VERNON GROVE SALLY E. THOMPSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9019 BLACK DOG ALLEY, EASTON, MD GLENN COLLINS, GRANDSON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION ! 01/26/2010 STEVENSVILLE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 21601 Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the disease, or complications that caused the death, Do not enter the disease, or complications that caused the death, Do not enter the disease, or complications that caused the death, Do not enter the disease, or complications that caused the death, Do not enter the disease, or complications that caused the death, Do not enter the disease, or complications that caused the death, Do not enter the disease, or complications that caused the death, Do not enter the disease, or complications that caused the death, Do not enter the disease, or complications that caused the death, Do not enter the disease, or complications that caused the death, Do not enter the disease, or complications that caused the death, Do not enter the disease, and the death disease, di shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Aspiration disease or condition resulting in death) Medical (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to lor as a consequence of -transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or liniury and that initiated events resulting in death) Last Due to (or as a consequence of): ending physician a use as the burial-Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No for Day Month Year should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 뎯 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 24 hours after death. Funeral Director: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ James Craffer Garris 0306A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomic Markai 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, **Funeral** (Month, Day, rea, 193 1 🕱 M 2 🗆 F Months Hours Yrs Director 238-56-9738 Aug Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10d. Inside City Limits Director MD Wicomico Salisbury 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 711 Spring Avenue 21804 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

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Yes 2 □ No Army
If Yes, Give
Year or Dates. Black, White, etc. African þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced American 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Board of Education Custodian of Health and Mental Hygie If item 27 is marked other r other traumatic event, t<u>i</u> Be Department of Health and Mental h Important If item 27 is marked ot any injury or other transmissions. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Vivian Jeffries Hattie Garris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillie Garris/wife 711 Spring Avenue, Salisbury, MD 21804 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State MD Veterans Cemetery 02/01/2010 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Road, Salisbury, MD 21 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DISEASE DROWAY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial-Physician/Medical P.O. Box 68760 attending p IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death signed by the a d be detached f 2 No 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed Yes 2 page death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes Physician: after death.

Director: After this certific Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be within 24 hours after de

To the Funeral Directo

completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Medica 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dead and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sul WEHBERG State **JAN 27** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** PAULINE ROXIE HUDSON JANUARY 11:22 PM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER 8. Date of Birth (Month, Day, Year NOV 26, 19 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2 🖼 F 220-28-2626 76 MARYLAND Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits death with the Marylar items 23a or 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at Director DELAWARE SUSSEX 1 ☐ Yes 2X No SELBYVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32219 LIGHTHOUSE ROAD 19975 U.S.A. Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify þ Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEPER/DOMESTIC WORKER HOME MAINTENANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HURLEY PURNELL BERTIE WALTERS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 32219 LIGHTHOUSE ROAD, SELBYVILLE, DELAWARE 19975 Department of Health
Important: If item 27
an Injury or other tr
on: **EDWARD** HUDSON / HUSBAND D.O.D. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages . 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ZOAR GOLDEN ACRES CEM. 2/5/2010 4 ☐ Donation 5 ☐ Other (Specify) BISHOPVILLE, MARYLAND 21. Sign the of Fyrd rul Service License 22. Name and Address of Facility WATSON FUNERAL HOME 211 S WASHINGTON STREET, MILLSBORO, DELAWARE 19966 1361 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aortic Stenosis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ongestive Sequentially list conditions, if any, reading to infriedate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Anemia burial-tran Due to (or as a consequence of) P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, uhmon 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate performed Vital 1 ∐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA ð 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After Division 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 28JAN 2010 E1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2322 Healthway Dr Berlin, MD 21811 Registrars

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month,

Pauline

rar's Signature

DHMH 17 Rev 1/2001

10-00668	Please Type or Print in Black Indelible Ink. Ensure All Copies Are L	_egible.	
Eugene Hawkins, Sr.	State of Maryland / Department of Health and Mental Hygiene	21	
1- For State	Certificate of Death	lives V	_

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011-00	_		-			-	_

		1- For State Registrar		Certific	cate of D	eath		7.0	Reg. No.	0 1 0	, 04040
Physicia Medical Exami	in/	1. Decedent's Name (First, Middl Eugene	e,Last) Hawk	ins, S				2. Date of D Month January	eath Day 23, 201		3. Time of Death 0145 hrs
		4a. Facility Name (if not institution Patapsco River at Rac	ce Road		E	City, Town, or Elkridge			Н	County of Deat	
Funeral Director		5. Social Security Number 214-32-8408	6. Sex 7. Ag 1 X M 2 F	e (In yrs. last bi	· · ·	If Under 1 Yea Months Day		LMin	3 2 / 1 °	Forei	rthplace (State or gn puntry) MD
1 tow any		Usual Residence of Decedent 10a. State 10b. County MD Howa	ard	10c. City, Towr	n or Location	d a o					10d. Inside City Limits 1 Yes 2 No
ne Maryland or 28a-f show any lifed at once.	Director	10e. Street and Number	Road Aver			Of. Zip Code	075		-	en of What Cou	71
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 M	arried 12. Was Decedent Armed Forces? 1 Yes 2			I las Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rica					ican Indian, Black,
hours after "natural", o Examiner ,	<u>a</u>	15. Decedent's Education (Spec	orced If Yes, Give Year or Dates: cify only highest grade com	npleted) 16a.	. Decedent's (s 2 X No Usual Occupa of working life	tion (Give ki	ind of work done use retired)		Specify: $B1a$	
21215-0036 uld be filed within 72 hours afte Mental Hygiene. marked other than "natural" c event, the Medical Examine	Completed	Elementary/Secondary (0-12) 10 17. Father's Name (First, Middle,	College (1-4 or 5	>+)	Brid	cklaye		Name (First, Middle	e, Maiden S	Mason:	гу
1215 d be file fental H narked o	Be	William 19a. Informant's Name/Relations		wkins,	•]	Mar	tha	Jo	ones	
e, MD 21215-003(and 2 should be filed within Health and Mental Hygiene. item 27 is marked other tha r traumatic event, the Medic	ို	Brenda Hawk				Rail R	Road	Ave. E11	ride	ge, MD	21075
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traun		20a. Method of Disposition 1	pecify:	ate crema	Mem.	_{place)} Garde	ens	1/30/201	.d I	ocation - City or Dunkirl	k, MD
		Islandy A. X. 23a, Part I. Enter the disease, or	evell	the death Dee							ne, P.A. ed., MĎ2067
Physician /Medical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)		olicated by H			Such as cal	rdiac or respiratory a	arest, shoc	or, or near	Approximate Interval Between Onset and Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a conse	equence of):							
cuted nd transit	l Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of);							
760, icate be executed g physician and the burial - transit	Medical	UNPENDED	AMENDED						T.		
Box 68760, e death certificate be the attending physic of for use as the bur	Physician/M	IF FEMALE: (3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unk	I LIVE DITUI		2 Fetal d	leath 3 [Ectopic p	pregnancy		. Date of delivery Month [/ Day Year
P.O. E es that the cigned by the detached		Part II. Other significant conditi		ı but not resultin	ng in the unde	rlying cause g	given in Part	16			the cause of death?
cords law requi	Completed by							per	s an opsy formed? 2 No	prior to death?	topsy findings available completion of cause of
Vital Rechysician: The this certificate	8	25. Was case referred to medical examiner?	Hospital: 1 Inpatie	nt 2 ER/C	Outpatient 3		Other	Check only one) Nursing Home 5	Residen	ice 6 🗸 Other	"Scene
on of Vital ending Physician: ath or: After this certifi	tion: To	1 V Yes 2 No 27. Manner of Death 1 Natural 5 Pend	28a. Date of Injur	ry 28b. ear) FOL	Time of Injury JND: 5 hrs	/ 28c. Injur	ry at Work? res 2 ✓ N	28d. Describe	e how injur		
Att de by	Certification:	3 Suicide 6 Could	tigation Jan 23, 2010 28e. Place of Inj mined (Specify) Rive	jury - At home, fa		actory, office b	uilding, etc.	or Town,	State)		ral Route Number, City e, Elkridge , MD
Divi	Medical (29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	nysician: To the best of my niner: On the basis of exan and manner stated.					e, and due to the caurred at the time, dat			
) 4	S S	29b. Signature and title of certifier				29c. License				ate signed (Mor	
JEM 1		30. Name and address of person Mary G. Ripple MD.	Deputy Chief Medic	cal Examine	r 111 Pc	enn Street,	, Baltimo	re, MD 21201			
Sta Regist	ite	31 Date filed (Month Day Year)	2010 32. Registrar	- 70	Marca	00					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day 11:45 PM 29, 2010 /Medical 4a. Facility Name of not institution, give street and number) Examiner 4h. City Town or Location of Death 4c. County of Death eci ara wa Veal 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign Country) **Funeral** Davs 214-24-7266 1 □ M 2 💢 F Months Hours Min. 8 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location show 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "nadical Examinar injust be restricted at Director 1 ☐ Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 4517 Funeral Point 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces' 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2 No Specify. ģ Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit, Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) ile lerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print) (dungmer) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) -heri Kton . Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date injury or 4☐Donation 5 ☐Other (Specify) 2-3-2010 North East Methodist Complex North East 21. Signature of Funeral Service Licer 32. Name and Address of Facility Strang + Fectey Family Funeral Home Churchmans Road DE Vin 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician FNFALTION MYOCAKDIAL Hours disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CURUNALY AKTELY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed HYPEN TENSION burial-trar Due to (or as a consequence of) aftending physician for use as the buris Physician/Medical HTPEKLIPIDEMIA 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mor 1 ☐ Yes 2 ☑ No Month Year 4 ☐ Pregnant at time of death Day 5 Other (specify) P.O. ed by the 9 Unknown signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 HYPOTHY ROLDISM 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe 1 ☐ Yes 2 🗷 🗝 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No hours after death 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within To the

State Registrar

304-306 North Street 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

29b. Signature and title of certifier

FEB 0

29c. License number

D0047711

Suite #3

2010

ELHTON MARYLAND 21921

se Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 10	01.01.0
State of Maryland / Department of Health and Mental Hygiene 🗸 🖯 🚶 💛	04048
Certificate of Death Reg. No.	

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any liury or other traumatic event, Ite Modical Exemitive must be notified at across or other traumatic event, Ite Modical Exemitive must be notified at ounce.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	Registrar			Ce	rtificate of	Death		Reg. N	lo.		
an	Decedent's Name (First, Middle, Last		•				2. Date of De Month	D		Year	3. Time of Death
al	Susie Frances Jon						Jan.	3	1 2	010	3:12p ^N
er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	r Location of Dea	ith	4	c. County of	f Death	
	441 Booth St.				E1kton				Cecil		
	5. Social Security Number 6. Se 218-70-4006	X ☐M 2☐F 7. A		52 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th ay, Year 0	r) 1957	9. Birthp Coun	lace (State or Foreig try) MD
	Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	ontion		-			1/	Od. Inside City Limit
5					cation					"	
Director	MD Cecil		ETE	cton	T						1√Yes 2 No
	10e. Street and Number				10f. Zip Code				Citizen of W	nat Count	try?
Funeral	441 Booth St.				21921				SA		
Š	11. Marital Status	 Was Decedent Armed Forces 		. 13.	Nas Decedent of H f Yes, specify Cuba	lispanic Origin? (an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	-		 America White, e 	an Indian, tc.
ò	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2♥ If Yes, Give Year or Dates:	No		I∐Yes 27∏ No	Specify:			Specify:	B1a	ck
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mo:	Elementary/Secondary (0-12)	College (1-4or	5+)		ekeeper	2)		Ow	n Hom	e and	d Others
BeC	17. Father's Name (First, Middle, Last)				•	18. Mother's Na	me (First, Middle,	Maide	n Surname)	
70 E	Leonard Jones Sr.					Faye C	1ore				
_	19a. Informant's Name/Relationship (Ty	rpe. Print)		19b. Mailir	g Address (Street			er, Citv	or Town, S	tate, Zip	Code)
	Sonya Jones/ Daugh	ter			ooth St.					·····, —,	,
1	20a. Method of Disposition		20b. Pla		sition (Name of natory or other place		Date		Location - C	ity or To	wn, State
	1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			ley M	emorial (Cemetery			rling	ton,	MD
	21. Signature of Funeral Service Licens	ee /		22 R	Name and Addres	ss of Facility I Funera	1 Home,	P.A			A BOOL
4	1			1 1	11 S. Que	een St.	Rising S	un,	MD 2	1911	
cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or as Due to (or as	a conseque	ence of):							
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3□	Ectopic pregnancy	у			23d. Date Mon		ry Day Year
<u>a</u>	Part II. Other significant conditions con	ntributing to death b	ut not result	ting in the ur	derlying cause give	en in Part I.					e cause of death? ably 4 🗗 Unknowi
Completed							24a. Was autop perfo	an osy rmed3	24b. W	ere autop ior to con ath?	sy findings available
BeC	25. Was case referred to medical			_		26 Plans of Do	1 ☐ Yes		10 11	Yes	2 ∐ No
	examiner?	lospital:	ant 2 🗆 🗆	B/Outpatie	t 3 DOA Othe		eath <i>(Check only o</i> Home 5 🗹 Resid		6 🗆 🗀	. (0	<u> </u>
medical certification, 10	27. Manner of Death 1	28a. Date of Inju (Month, Da	ıry y, Year)	28b. Time of Injury	28c. Injury Work		28d. Describe h	now inju	ury occurred	i	Route Number,
enical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examin	sician: To the best ner: On the basis of and manner st	of examination	ledge, death on and/or in	occurred at the tir restigation, in my o	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(date ar	(s) and mar	ner as st	ated. the cause(s)
A	29b. Signature and title opertifier	8MD.			29c. License	o 02332	2.	29d. D	ate signed		
	30. Name and address of person who co	mpleted cause of c	leath (Item 2)	23a) (Type, I	29c. License Do Print) High St	Elle	eten Mo	210	921.		

Registrar

State of Maryland / Department of Health and Mental Hygiene amend item 1 - State Registrar #8, per fh, 1/28/2010 tj Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Holland Bernice 10:15 DM Ginn Medical Facility Name (if not institution, give street and numb 4b. City, Town or Location of Death **Examiner** 4c. County of Death oastal 4090 Wicomico Jalis bu Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 2/6/1926. Birthplace (State or Foreign **Funeral** 1 M 2 1 F Months Days Hours (Month, Day, **Director** 219-14-4272 83 Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Pocomoke 1 XYes 2 ☐ No Worcester Maryland 10e. Street and Number 10g. Citizen of What Country? Funeral 809 Second 21851 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Be Completed by Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 3 🛱 Widowed 4 🗌 Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Salon Beautician Beauty 11th grade Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ SR. Raymond Ella Ginn Collick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cane Mikiam - Neice Pocomoke Haleys 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place Shiloh v.m.c. Cemetery 130/10 rocomo Ke 21. Signature of Funeral Service Licensee 22. Name and Addres of Facility Anthony E. Ward F. H. Arthur E. Woul 30639 Princess Home, md, 21853 Ave 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown 4 Pregnant at time of death 5 Other (specify) Month Day Year n signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy performed? Yes 2 \bullet No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be (26. Place of Death (Check only one) in 24 hours after deam. he Funeral Director: After this ce noleted filled in by the funeral dire Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural injury 5 Pending work?
1 Yes 2 No 2 Accident
3 Sulcide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Contributing Nurse Practionar T. the basis of my including open and a state and place, and due to the cause(s) and manner stated (Check unity sine) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 01-23-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BELLOSO, M.D. 5302 CHINABERRY DR. SALISBURY, MD 21801 GREGORIOM, Begistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Physician /Medical Examiner The law requires that the death certificate be executed Box 68760. P.O. Division or Vital Records,

Hospital or Attending

death.

with

death v

filed within 72 hours after

Maryland 21215-0036

Baltimore,

burial-trar attending physical at the second s certificate has be irector, page 2 s director, To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu

27. Manner of Death

5 Pending investigation 1 Natural 2 Accident 3 ☐ Suicide 4 ☐ Homicide

6 ☐ Could not be

28a. Date of Injury (Month, Day Year) 28b. Time of Injury

and manner stated.

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

HALL HIGHWAY, CRISFIELD MD 2181

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29b. Signature and title of certifier 0

JAN 25 2010

29d. Date signed (Month, Day, Year) 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. VIJAYKARUMBUN ATHAN

31. Date filed (Month, Day, Year)

32. Registrar's Signature Sale

State Registrar

Medical

XHI

10-00869	
Larry Haines	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Larry Haines		1- For State Registrar	ate of Marylar	-	tificate o		ind Mental i		eg. No. 201	0 04051
Physiciar Medical Examin	n/	1. Decedent's Name (First, Midd	le,Last) RY MATTHEW	HATNES				2. Date of Dea Month January 3		3. Time of Death 1613 hrs
		4a. Facility Name (if not institution			1	4b. City, Town,	or Location of Dea		4c. County of De	
		519 Alliance Street				Havre de			Harford	
Funeral Director		5. Social Security Number 215–56–1938	6. Sex 7	7. Age (In yrs. la	ast birthday) Yr:			lin.	rth(MM/DD/YYYY) 9. Fo 5/1951	Birthplace (State or reignPENNSYLVAN) Country)
any	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loca	tion				10d. Inside City Limits
	ᅵ	MARYLAND HAF	RFORD			HAVR	E DE GRAG	Œ		1 X Yes 2 No
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 519 ALLIANCE	STREET			10f. Zip Code	21078	1	Og. Citizen of What CUNITED	
eath with items 23, ust be not	Funeral	11. Marital Status 1 Never Married 2 X N	arried Armed For				Hispanic Origin? (pan, Mexican, Puer		14. Race - Ar White, etc	nerican Indian, Black, c.
s after de risal", or niner m	ব	3 Widowed 4 Dir 15. Decedent's Education (Spe	or Dates:				BLACK			
72 hour	eted	Elementary/Secondary (0-12)			during n	nost of working I	pation (Give kind o ife. DO NOT use re		16b. Kind of Busine	
5-0036 led within 7 Hygiene. to other than	d Wo	12			SALE	S CONSU			AUTO SA	LES
e filed ved oth	Be C	17. Father's Name (First, Middle ROBERT DUNSEN					18.Mother's Nan		Maiden Surname)	
2121 hould be fi nd Mental is marked itic event,	Ĕ	19a, Informant's Name/Relations			19b, Mailin	g Address (Str	eet and Number o	r Rural Route Nur	mber, City or Town, St	tate, Zip Code) ZEST CHESTER,
and 2 sho and 2 sho ealth and 2 icm 27 is traumat	-	SHIRLEY HAINES 20a. Method of Disposition	S / SPOUSE	20b. F	2108	UNION C	1. AP1.,	S. BALI'	TMORE ST, "	PA 19382
More		1 Burial 2 X Cremation 4 Donation 5 Other S		II State	rematory or ot	ther place)	., INC	02/05/10	WEST CHE	STER, PA
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	Ì	21. Signature of Funeral Service	Licensee		22. I	Name and Addre	ess of Facility TT FUNERA	AL HOME,	P.A.	
Physician	+	23a. Part I. Enter the disease, or failure. List only one cause	complications that cau	used the death.	Do not enter t	52 LEWT the mode of dyin	S STREET ng, such as cardiac	or respiratory arr	DE GRACE, est, shock, or heart	MD 21078 Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease	a. Atheros			liovascu	ılar dise	ase		Death Death
		or condition resulting in death) Sequentially list conditions,	Due to (or as a c	onsequence of):					
	if any, leading to immediate Due to (or as a consequence of):									
cecuted and - transit	Exau	(Disease or injury that initiated events resulting in death) Last	Due to (or as a c	T.						
60, ate be exec hysician ar e burial - ti	AMENDED AMENDED 23a,27,permE, g900 2/18/10 TT IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (Specify) 23d. Date of delivery Month Day									
876C tificate ng phys	Me.	IF FEMALE: 23b. Was decedent pregnant in t	23c. If yes, ou	tcome of pregr	nancy	etal death	B Ectopic pregi		23d. Date of delive	very Day Year
	ysicia	past 12 months? 1 Yes 2 No 9 Un	known 9 Unknow	nt at time of dea n		ther (Specify)				
s, P.O. Brires that the designed by the	by Phys	Part II. Other significant condi	ions contributing to	death but not re	sulting in the o	underlying cause	e given in Part I.			to the cause of death?
rds, Prequires t				-				1 Yes		Probably 4 Unknown autopsy findings available
e law requir	ompleted							autop	osy prior rm <u>ed</u> ? death	to completion of cause of
tal Recian: The certificate ector, page	္စ္မ	25. Was case referred to medica	1			26.Pla	ce of Death (Chec		2 10	res 2 NO
F Vital Physician: tr this certification:	6 B	examiner? 1 V Yes 2 No			ER/Outpatient				Residence 6 🗸 Ot	ther: Scene
on of noting Ph		27. Manner of Death 1 X Natural 5 Pen	28a. Date of (Month, C ding	Day,Year)	28b. Time of I	1 28c. Ir	jury at Work? Yes 2 No	28d. Describe i	how injury occurred	
ivisior or Attend after death Director:	Certification:	3 Suicide 6 Cou	a not be	of Injury - At ho	me, farm, stre	et, factory, office	building, etc.	28f. Location (S or Town, S		Rural Route Number, City
Di pspital hours a nneral I		4 Homicide	rmined (Specify)					J.		
Divis To the Hospital or At within 24 hours after d to the Funeral Direct completely filled in by	Medical	(Check only	hysician: To the best of miner:On the basis of and manner sta	examination an						
2 4 8 5 8	æ	29b. Signature and title of certific					nse number		29d. Date signed (• • • • • • • • • • • • • • • • • • • •
\sim	ļ	Un M. January 31, 2010)10
0		30. Name and address of persor Ling Li, MD Assista	who completed cause int Medical Exam			et, Baltimore	e, MD 21201			
Star Registra	-	31. Date filed (Month, Day, Year)		istrar's Signatui						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State	of Marylar		artment of H rtificate of L			ne 0 1 0	04052	
		馬	1. Decedent's Neme (First, Midd	le, Last)					2. Date of Death Month	Day Year	3. Time of Death	
	Physicia /Medic	_		LUCII	LE S. HUI	NTER				1/2010	1:15 A M	
	Examin		4a. Facility Name (If not institutio	n, give street and n	umber)		4b. City, Town, or	Location of Death		4c. County of Dea	of Death	
			CAROLIN	IE NURSINO				DENTON			ROLINE	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs.		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) C	rthplace (State or Foreign country)	
	Director		214-I4-4688 Usuel Residence of Decedent		92	2 113.			1/25/19	917	MARYLAND	
	land		10a. State 10b. County	/	10c. Ci	ity, Town or Lo	ocation				10d. Inside City Limits	
\bigcirc	Mary	ţō	MARYLAND DO	ORCHESTER			C	AMBRIDGE			1 □ Yes 2√2 No	
7	r 28s	Director	10e. Street and Number				10f. Zip Code			. Citizen of What C	Country?	
ን	death with the Maryland ms 23a or 28s-f ahow rmust be mulified at		17	06 DARK R	D.			21613		Į	JSA	
	deat	Funeral	11. Marital Status	12. Was De	cedent Ever in U	J.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp. n. Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rece - Am Black, Wh		
တ္က	within 72 hours after ene. then "natural", or Ite he Medical Examina	/Fu	1 Never Married 2 Mai	rried 1 TYes	s 2) ⊠No Give		1 ☐ Yes 2 ☑ No	Specify:	,	Specify:		
	ural',	d by	3X Widowed 4 □ Divorced	d Year or	Dates:	1					WHITE	
<u>v</u>	nat	lete		nt's Education est grade complete	d)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of work	ring	Sb. Kind of Busines	s/industry	
12	within ene. then	Completed	Elementary/Secondary (0-12)	Coltege	(1-4or 5+)			MAKER		OW	N HOME	
0 0	filed Hygi other		17. Father's Name (First, Middle,	. Last)		1		18. Mother's Nam	e (First, Middle, Ma	iden Sumame)		
au	Mental Mental arkad o	To Be	TH	OMAS H. SI	HERMAN,	SR.			LILLI	AN CHALK		
2	& B E E	-	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailir	ng Address (Street a	and Number or Rui	al Route Number, (City or Town, State,	Zip Code)	
	1 and 2 Health a Iam 27 Is		NYLENE L. SHERN	MAN / SISTE	R-IN-LAW		170	06 DARK RD	., CAMBRID	GE, MD 2161	3	
timore,	of Health of Health filem 27		20a. Method of Disposition 1 ☐ Burial 2X Cremation	3 □Romoval fro		Place of Dispo cemetery, crei	osition (Name of matory or other place		Date 20	Oc. Location - City o	r Town, Stete	
Ĕ	Pages nent of I ant: # It ury or o		`4 □Donation 5 □ Other (SHORE CF	REMATION CEN	TER 1/2	1/2010	CAMBE	RIDGE, MD	
Ø	permit. Pages Department of Important: #1 any injury or o		21. Signature of Funeral Service	Licensee .		22	2. Name and Addres	ss of Facility				
<u> </u>	205 g a		1(0)4/	h							MBRIDGE, MD 21613	
- An-			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that t only one cause of	t caused the dea n each line.	th. Do not ent	ter the mode of dyin	g, such as cardiac	or respiratory arres	it,	Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition	a	EM	00	TIC				Years	
93	/Medical Examiner		resulting in death)	Due	o (or as a conse	quence of):					1	
		100	Sequentially list conditions, if any, leading to immediate	b. Due 1	o (or as a conse	dilence ot).						
	ted	nln	Cause (Disease or injury	< ∷	(,						
	al-tra	Examiner	that initiated events resulting in death) Last	c	o (or as a conse	quence of):						
8760,	ate be executed hysicien and the burial-transit	dical 8		d.								
9	tificat ng phy as the	ledi								1		
Вох	death certific e attending p ed for use as	N/N	IF FEMALE: 23b. Was decedent pregnant		outcome of pregressions a birth 2 Fet		□Ectopic pregnancy			23d. Date of d		
	it the death cer by the attendir tached for use	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of		Other (specify)			Month	Day Year	
о. О	at the	Physician/Med	9 Unknown						00. 0:4		to the cause of death?	
	The law requires that the ate has been signed by the bage 2 should be detache	þ	Part II. Other sig incant condit	ions contributing	death but not re	suiting in the u	ind riying cause giv	en in Part I.			Probably 4 Unknown	
ord	w requir been si should	ted	CICALON	47-1	14.	65-16	me /					
ec	law las b	Completed							24a. Was an autopsy performe	prior to	autopsy findings available completion of cause of	
<u> </u>	The cate h	S								1 Y	s 2□No	
Vita	ician Sartifi ector	Be	25. Was case referred to medic examiner?	Hoenital			Oth	or /	th (Check only one		-	
Division of Vital Records,	Attending Physician: If death, ector: After this certificity the funeral director.	1.	1 Yes 2 No 27. Manner Death		Inpatient 2	28b. Time o	nt 3 DOA	wursing H	ome 5 Resident 28d. Describe how		pecify)	
uo	ding h. After fune	tlon	1 ☑Natural 5 ☐ Pend	/8.4	onth, Day Year)	Intury	Wor	k? Yes 2 □ No				
İSİ	Attendi death. ctor: /	flca	3 ☐ Suicide 6 ☐ Could	I not bo	ce of tnjury - At I	home, farm, st	reet, factory, office		28f. Location (Stre	et and Number or	Rural Route Number,	
<u>S</u>	after after Dire	Certification;	4 Homicide	bu	ilding, etc. (Spec	uty)			City or Town,	State)		
	To the Hospital or Attending Physicien: The lay within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2						th occurred at the tin					
	he Hin 24 he Fi	edical	one)	and m	anner stated.	iation and/or ii						
	To t To t	Σ	29b. Signature and title of certific	er (/ /		29c. Licens	e number	29	d. Date signed (Mo	nin, Day, Year)	
	1		· pen	1	XX	54	40D3	15/1		1-01-1		
	0)		30. Name and address of person	n who completed ca	ause of death (Ite	m 23a) (Type,	Print)	ST N	o it-	1140	21629	
			31. Date filed (Month, Day, Yea.	1) 32	. Regis ar's Sign	nature -	river	JE JE	- NON	1/100		
	Sta Registi			25 2010	Desens	1	Back					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND#20 open FH State of Maryland State of Maryland HEALIH DEPT. CMH Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Edna Carroll Hall 2010 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Riderwood Village Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 - M 2 X F Days Months Hours Min 472671923 060-18-0633 Yrs Director 86 Usual Residence of Decedent 28a-f show 10b. County or than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3114 Gracefield Rd. WC209 20904 USA 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates Specify Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Homemaker Home other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of ည John Gardner Pauline H. Westphal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; If item 27 is any injury or other trai Carroll E. Gazelle/ Daughter 200 May Lane, Edgewater, MD 21037 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1/27/2010 Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2/27/10 Edgewater, Maryland 21. Signature of Funeral Semice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home Ulke 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Chronic obstructive pulmonary disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami sician and burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò hypertension, osteoporosis, coronary artery disease Records, Completed 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? history of myocardial infarction 24a. Was an has autons 1 Yes 2 No Yes 2 No or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical of Vital B 26. Place of Death (Check only one) 1 ☐ Yes 2 👿 No Other: ျ 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: After 28d. Describe how injury occurred X Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Division s after death. Accident Suicide Investigation 6 Could not be 2 Accident
3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D44556 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mor egistrar's Signature State

9. Birthplace (State or Foreign Country) New York

White

10d. Inside City Limits

Interval Between Onset and Death

Day

Year

1 Tes 2 No

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month / 19/2010 Laurence W. Hartge 12:10am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b City Town or Location of Death 4c. County of Death 257 Hanover St. Annapolis Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 0/31/1916 1 **X** M 2 □ F Months Days Director 577-10-1479 93 Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code items 23a or 10g, Citizen of What Country? Funeral 257 Hanover St. 21401 USA Page 1 and 2 should be filed within 72 hours after death vertent of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 XYes 2 No WWII
If Yes, Give Black, White, etc. and Mental Hygiene.
is marked other than "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White Specify: XX Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Director Nautical Museum Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Oscar Emile Hartge Alice Wayson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Patricia Hartge Daughter 5508 Montgomery Street Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2XXCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 1/22/2010 Glen Burnie, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between erval Between nset and Death - Wow 145 Immediate Cause (Final Priysician/ disease or condition lanous Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or imjury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the atten detached for u 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death
Unknown Yes 2 No g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 2 No 3 Probably 4 Unknown Completed MelliTus Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 10 1 Yes 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 No Investigation Could not be Accident after deatl Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu and title of certifier 29d. Date signed (Month, Day, Year) 965 2016 30. Name and address

State Registrar

31. Date filed (Mont

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Shirley Anne Henderson Medical Facility Name (if not institution, give street and number) Examiner 4c. County of Death If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F Months Days Hours Min. Director 577-32-4814 81 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location hours after death with the Maryland 10d. Inside City Limits Director 1 ☐ Yes 2 💆 No Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 78 Hingham Lane 21811 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Specify: Completed white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry oe filed with.
**tal Hygiene.
**er than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other th permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important if item 27 is marked other tamy injury or other traumatic event, the once. Book Keeper Catholic Church Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Francis McGowan Celestine Gerlitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>War</u>ren A. Henderson-Husband <u>78 Hingham Lane Berlin, Maryland 21811</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cem. 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Jan. 27,10 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic 22. Name and Address of Facility Burbage Funeral Home William Street Berlin. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ areine disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Month signed by the sid be detached f 1 ☐ Yes ∠ x 9 ☐ Unknown Unknown Part II<u>. Ot</u>he<mark>r significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? p\ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate funeral director, pag 1 Yes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 💢 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) HD 5 Pecs 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending Accident
Suicide 2 No Investigation Could not be within 24 hours after death

To the Funeral Director:,
completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier 1 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 01-23-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORIO M. BELLOSO, MD.; 5302 CHINABERRY DR. SALISBURY, MD 21801 31. Date filed (Month, Day, Year) 32. Pogistrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Month Annie J. Hoey 8:45 AM 01 Medical 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospice at the Lake Coastal Salis bury Wicomico . Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 225-05-8229 1 □ M 2 K F Days Min. Hours 07 09 1913 96 Director Virginia Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Wicomico Maryland Parsonsburg 1 🗆 Yes 2 😾 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 7888 Parsonsburg Road 21849 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: "natura!" 3 X Widowed 4 Divorced white Year or Dates. of Health and Mental Hygiene. If item 27 is marked other than "natur ir other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) manager property Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve anse. မ Wade Mays Orie Mays 19a. Informant's Name/Relationship (Type, Print)
Donald Mitchell son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 525 Melrose Ave., Winter Park, FL 32789 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 🔀 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) 1 28 10 Salisbury Crematory Salisbury, MD 22. Name and Address of Facility
Holloway Funeral Home Professional Association 21. Signature of Funeral Service Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death TONSILLAR Physician/ MACIGNANT disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year cate has been signed by the a page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No Yes 1 🔲 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: E No Other: ျ 1 🗌 Yes HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence Cher (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending To the nospector within 24 hours after death.

To the Funeral Director: Aft Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Qertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 6 Huspy BOP WAST 31. Date filed State Registrar

10-00905 Paul Harrison

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Paul Harrison	F	I-ForState Registrar		ate of Maryla		artment of rtificate of		Mental H	R	eg. No. 201	0 0405	
Physician Medical Examine		Decedent's Name PAUL		e,Last) RRISON					2. Date of Dea Month February	Day Year	3. Time of Death 0014 hrs	
	ľ		f not institutio	n, give street and nu	ımber)		4b. City, Town, or L Bowie	ocation of Death		4c. County of De Prince Geor		
Funeral Director	- 1	5. Social Security N	lumber	6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24Hrs Hours Min.	_	rth(MM/DD/YYYY) 9. I	eignMARYT.AND	
0	L	212-72-45 Usual Residence of		1XM 2_F	51	- Yrs			11-16-	-1958	Country)	
2 hours after death with the Maryland "natural", or items 23a or 28a-f show any Examiner must be notified at once.	1		10b. County	GEORGE	10c. City UPPE	, Town or Locat	BORO				10d. Inside City Limits 1 X Yes 2 No	
the Maryland a or 28a-f sh tified at once		10e. Street and Nur		GLORGE	0111	TIANI	10f. Zip Code		1	0g. Citizen of What Co		
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er death with t		11. Marital Status 1 XNever Marrie	ed 2 Ma	arried 12. Was Dec	cedent Ever in U orces? 2 No		s Decedent of Hisp es, specify Cuban,			o- 14. Race - American Indian, 8lack, White, etc.		
s after of niner m	⋧┞	3 Widowed		orced If Yes, Give Yes or Dates: cify only highest grad	er	1	Yes 2 No			Specify.	ACK	
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215-0036 be filed within 7 ntal Hygiene ked other than ent, the Medical Bo Comple	5	11 t 17. Father's Name (Last)		<u> </u>	LABORER	8 Mother's Name	(First Middle I	GOVERNI Maiden Surname)	MENT	
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Baltimore, permit. Pages I ar Department of Hec Important: If ite injury or other tr		4 Donation 5 21. Signature of Fur	Other Sp	ecify:			ON CEMET			CLINTON, FUNERAL F		
Bal permi Depa Impo		21. Signature of Full	5. M	-hal						MD 20785	IOME	
Physician Modical	1	failure. List onl	y one cause							est, shock, or heart	Approximate Interval Between Onset and Death	
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i d	<u>.</u>	Sequentially list cor if any, leading to im	mediate	b. Due to (or as a	consequence o	ıf):						
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60, ate be execut shysician and burial - tra		F FEMALE:		23c. if yes, (Ba,PII,2 outcome of preg	27,perm	E g900 2	/23/10 7	TT	23d. Date of delive	ery	
Box 6876 e death certificate the attending phy ed for use as the I		3b. Was decedent p past 12 months	?	I Tive p	irth ant at time of de	ath -	tal death 3 ner (Specify)	Ectopic pregna	ncy	Month	Day Year	
). Boy the death by the att		1 Yes 2 N		9 Unkno			nderlying cause giv	en in Part I	23a Didte	obacco use contribute t	o the cause of death?	
P. G. that	3		cance		death but not n	esaiting in the d	nderrying cause gri				obably 4 Unknown	
Records, The law requires ficate has been sig. page 2 should be	אומומ	-							24a. Was autop	sy prior to	autopsy findings available completion of cause of	
Rec i: The la ifficate h		25. Was case refern	ed to medical			_	26 Place o	of Death (Check o	1 Yes	rmed? death? 2 No 1		
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ivisior or Attenc after death Director: in by the		2 Accident 3 Suicide	6 Could	not be	e of Injury - At he	ome, farm, stree	t, factory, office bui	ilding, etc.	28f. Location (S		Rural Route Number, City	
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2	2	29b. Signature and	7.				29c License O.C.M			29d. Date signed (M February 1, 201		
0	3		ess of person	who completed caus								
/L State	<u>ا</u>	Donna M. Vi 31. Date filed (Mont)			dedical Exam		Penn Street, I	Baltimore, MI	D 21201			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 9:22 a M Madeline Jones January 29, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Hospital Cheverly Prince George's If Under 1 Year 5. Social Security Number If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 X I Director April 22, 1940 69 MD 220-36-9094 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the twarden Evanties in the sage of 28a-f shot event, the twarden Evanties in use to rollf of a 1 XYes 2 □ No Director Prince Georges Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5418 Gallatin Street 20781 USA by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🗷 No Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Cook Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Health and Mental H Important: If Item 27 is marked oth any injury or other traumatic even Be James Owen Holland Ethel Gladys Thomas ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5418 Gallatin Street, Hyattsville, MD 20781 Nathaniel L. Hurley - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ernestine Jones Cemetery | February 5, 2010 | Chesapeake Beach, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home, P.A. Glady a. Sewell 1451 Dares Beach Rd., Prince Frederick, MD 20678 Approximate Interval Betwo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. erval Between set and Death Immediate Cause (Final **Physician** 10U2S disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.O. 1 ☐Yes 2 No s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to 23e. Did tobacco use contribute to the cause of death? ath but not resulting in the underlying cause given in Part I Records. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy The performed' Division of Vital 1 ∐Yes 2 No 2 🗆 No To the Hospital or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this of 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. neral Director; A 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Skaminer: On the basis of examination and/oy investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 2 ☐ Medical 5 (Check only one) 29b. Signature and title of certifier 29c. License number 2016 30. Name and address of person who completed cause of death (yem 23a) (Type, Print), YEM 10 31. Date filed (Month, Day, 32/Registrar Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Carl Edward Johnson, Jr. 9:45a[™] 2010 Jan. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 1784 East Old Philadelphia Rd. E1kton Cecil If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Days Hours 1 ☑ M 2 ☐ F 222-30-6852 63 Nov. 6, 1946 Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Marical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Director MD Ceci1 E1kton 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 1784 East Old Philadelphia Rd. 21921 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: \$ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teamster Transportation 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Carl Edward Johnson, Sr. Norma Winifred Hewitt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Johnson/ wife 1784 East Old Philadelphia Rd. Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2/6/2010 1X Burial 2 ☐ Cremation 3 ☐ Removal from State North East Methodist Cemetery 4 ☐ Donation 5 ☐ Other (Specify) North East, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility R.T. Foard and Gee Funeral Home Part 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart time. List only one suse on each line. Approximate Interval Between Onset and Death Immediate Cau = IFinal disease or condition resulting in death) **Physician** ractor /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burlal-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Day 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 2 1 No 1 ☐ Yes 25. Was case referred to medical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 🗆 No 2 Accident 3 ☐ Suicide 6 □ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifie 29d. Pate signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Ma MO 32. Registrar's Signatu

DHMH 17 Rev 1/2001

Registrar

FEB 0 2 2010

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 19 2010 1830 January James Johnson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Anne Arundel Medical Annapolis Center Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 6. Sex Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Days Hours Min. 1 🔀 M 2 🗆 F Director Yrs 218-24-6480 Maryland ant Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits must be notified at Director 1 X Yes 2 □ No <u>Maryland Anne Arundel</u> Shady Side 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral 23a USA 5908 Shady Side Road 20764 27 is marked other than "natural", or items: traumatic event, the Medical Examiner mus filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify If Yes, Give Year or Dates Specify: Black "natural" 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Johnson, Hauling 6th General Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ٩ Alverta Sellman Walter Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 Barbara N. Johnson (Wife) Shady Side, Md. 5908 Shady Side Rd. or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ō <u>=</u> **Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Owensville, Md. Chews Cemetery 1/23/10 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sons Mortuary, Annapolis, Md Reese vry B, Beese MOSY 83 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ o Ca disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): physician and the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Box in the past 12 months? Month Day Year signed by the a 1 Yes 2 G 2 No that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably Unknown Records, 1 Yes 2 No page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital 2 No ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury 1 Natural 5 Pending work? 2 No Accident Investigation s after deat | Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or e and title of c 29c. License number 29b. Signat 0163 person who completed cause of death (Item 23a)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended #1 - State 20a, FH, TCHD, 1/22/10 pha Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 2010 20 Jennie Lee Johnson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Chesapeake Woods Center Cambridge Dorchester 5. Social Security Number . Age (In yrs. last birthday) If Und 8. Date of Birth (Month, Day, Year) 9. Birthplace Country) (State or Foreign 6. Sex **Funeral** Davs Months Hours 1 M 2 X F Yrs Alabama Director 11-22-1936 216-54-9512 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County ral", or Items 23a or 28a-f show Examiner must be notified at 1 XYes 2 □ No Director Md. Talbot Easton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 45 South Washinton Street 21601 14. Race - American Indian, Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □Yes 2 █ If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Specify: Ş Q 3 Widowed 4 ☐ Divorced Black "natural" Completed th and Mental Hygiene.

7 Is marked other than "nature traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Someone else'shome Home maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown ၉ Nicey McDaniel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Gloria J. Cummings/Daug 805 Dover Brook, Faston, Maryland 21601

Date | 20c. Location - City or Town, State | 20c. Location - City o item 27 r other t 20b. Place of Disposition (Name of cemetery, crematory or other place)
Direct Crematory 20a. Method of Disposition ₽ + Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. = ১ Crematory Dover, Delaware 01-25-10 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bennie Smith Funeral Home 21 Signature of Funeral Service Licenses 426 Dover Street, Easton, Md. 21601 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** MEATS disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) is certificate has been signed by the director, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Cosomo autopsy 2 140 Rena 1 ☐ Yes 9.14 Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only onle) Hospital: Other: 4 Surring Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After t ↑ Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No ✓2 ☐ Accident after death Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 NARR D.0 100 31. Date Wed (Month, Day, Year) JAN 22 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** ic Mai Corres 2010 /Medical c. County of Death 4a. Facility Name (If not institution, give skeet and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday)

3 Yrs. 5. Social Security Number **Funeral** Days 1 X M 2 □ F 219-75-7350 Maryland July 02,2006 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location show aţ Severna Park Anne Arundel MD 1 ☐ Yes 2X No Director ms 23a or 28a-f s must be notified 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21146 USA 114 Giddings Avenue or items 23a Funeral death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No 11. Marital Status Black, White, etc. Examiner filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 📆 No Specify. If Yes, Give Year or Dates Specify: White 9 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education the Medical (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) NA NA ŃΑ permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Deanna C. Joss Brian K. Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 114 Giddings Avenue Severna Park, MD 21146 Brian K. Johnson / Father 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Jan. 25, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 2010 22. Name and Address of Facility Barranco & Sons, Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Momy 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Revirably J. M. Due to (*r as a consequence of): **Physician** Syncitial disease or condition resulting in death) /Medical **Examiner** disease if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) requires that the death certificate be executed burial-trar that initiated events and resulting in death) Last Due to (or as a consequence of) physician Physician/Medical the as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Month Year in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 \ No the been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> 1 TYes 2 No 3 Probably 4 Unknown Completed plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 2 🗆 No 1 Ves 1 Tyes Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: (1 Linpatient Other: 4 🗆 Nursing Home 5 🗆 Residence 2 XNO 2 ER/Outpatient 3 DOA 6 Other (Specify) 1 Yes this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide

Box 68760, P.O. Division of Vital Records,

Maryland 21215-0036

Baltimore,

Hospital or Attending Director: After death. after a 24 hours a within 2

State Registrar

29c. License number

Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

and manner stated.

600 North Wolfe St, Baltimore, MD, 21287

ang 32. Registrar's Signature 31. Date filed (Month, 2010

29a, Certifier

(check only one)

29b. Signature and title of certifie

Medical

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ohn Richard Ke		State of Maryland / Department o 1- For State Certificate o		id Mental F		Reg. No	2010	04064
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,Last)			2. Date of De	ath	Year	3. Time of Death 2340 hrs
Medical Exami	ner		4b. City, Town, or	r Location of Deat	January		c. County of Death	
<i>.</i>		Calvert Memorial Hospital	Calvert				Calvert	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Yea Months Day		n.		I/DD/YYYY) 9. Bir Foreig	an a
Director		266-83-4525 1 M 2 F 43 Yrs Usual Residence of Decedent			May 2	20,	1966 ^{co}	^{untry)} Florida
any		10a, State 10b. County 10c. City, Town or Local	tion	•				10d, Inside City Limits
Maryland 28a-f show d at once.	tor	MD Calvert Huntingt				10 00	(140.10	1 Yes 2 X No
ith the Maryland 23a or 28a-f sho notified at once.	Director	1341 Duchess Lane	10f. Zip Code	0639		TUg. Cit	tizen of What Cou USA	nury?
with th		11. Marital Status 12, Was Decedent Ever in U.S. 13. Wa	as Decedent of Hi	spanic Origin? (S		lo-	14. Race - Amer	ican Indian, Black,
death	Funeral	1 Yes 2 X No	res, specify Cubar		o Rican, etc.)		White, etc.	L * 4
rs after ural", miner	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a Deceder	Yes 2 X No		work done	16b.	Specify: W. Kind of Business/	hite
72 hou n "nati	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	nost of working life			1.02		
5-0036 led within 72 hours after Hygene. other than "natural", the Medical Examiner	ompleted	12 Mai	il Clerk				Banking	
21215-0036 Juld be filed within 7. Mental Hygiene. marked other than ic event, the Medical	Be Co	17. Father's Name (First, Middle, Last) John W. Kern		18 Mother's Nam	e (First, Middle .beth F		,	
	To E	19a. Informant's Name/Relationship (Type, Print)	-	et and Number or	Rural Route No	umber, C	City or Town, State	, Zip Code)
Baltimore, MD permit Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati		John W. Kern (father) 1341 20a Method of Disposition 20b Place of Disposition	Duchess		ntingto		MD 2063	
Ore, ges la t of He :: If he		1 Burial 2 X Cremation 3 Removal from State Lee Crem	ther place)		b 4		linton, I	
nit. Pa artmen oortant		4 Donation 5 Other Specify.					Home Cal	
Dep Dep Inju		Sary J. Gott	125 Sout	hern Mar	yland B	31vd	0wings	, MD 20736
Physician Medical		23d. Part I. Enter the disease, or complications that caused the death. Do not enter t failure. List only one cause on each line.	the mode of dying,	, such as cardiac	or respiratory a	rrest, sh	ock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a Hemopericardium Due to (or as a consequence of):						Death
		Sequentially list conditions, b. Aortic Dissection						
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated						
ecuted and transit		events resulting in death) Last Due to (or as a consequence of):						
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Box 68760, e death certificate be ex the attending physician reference as the burial		IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fe	etal death 3	Ectopic pregn	anou.	23	3d. Date of delivery	y Day Year
x 68 th certif		past 12 months? A Pregnant at time of death 5 0	etal death 3 ther (Specify)	copic pregn	ial icy		WOTH!	Jay Teal
the deal	Physi	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the i	underlying cause	oiven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn.	ρ				1 Y	es 2	No 3 Prof	oably 4 🗸 Unknown
rds,	Completed				24a. Wa	s an opsy		topsy findings available completion of cause of
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ding Physic	<u>۲</u>	27. Manner of Death 28a Date of Injury 28b Time of		ary at Work?	28d. Describe		ence 6 Other	
ion (tending eath.	ation	1 Natural 5 Pending 2 Accident Investigation (Month, Day, Year)	1	Yes 2 No				
Division of Vital Records, pital or Attending Physician: The law require ours after death. neral Director: After this certificate has been sifiled in by the funeral director, page 2 should the control of the funeral director.	ertification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre	et, factory, office t	building, etc.	28f. Location or Town,		and Number or Ru	ral Route Number, City
lospita H hours Tuneral	ပ	29a. Certifier 1 Certifying Physicians. To the best of my knowledge, death occur	rred at the time. d	late and place, an	d due to the cau	use(s) a	nd manner as stat	ed
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated						
F 3 F 3	Ž	29b. Signature and title of certifier	29c Licens	se number			Date signed (Mo.	
		30 Name and address of person who completed cause of death (Item 23a)	0.0.	. IVI. L.		_ rei	oruary 1, 2010	,
den 3			Street, Baltim	ore, MD 2120)1			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #7 State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Russell William Keller SR Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 305 Johnson Street Allegany Westernport Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 09/01/1947 9. Birthplace (State or Foreign **Funeral** 1 X M 2 F Hours Country) Franklin 62 67 **Director** 219-56-9598 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Allegany MD Westernport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 305 Johnson Street 21562 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. "natural", Specify: White 3 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Welder Construction Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Daphne Ann Weese James William Keller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Keller (wife) 305 Johnson Street, Westernport, MD 21562 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1
Burlal 2 Cremation 3 Removal from State 4v Donation 5 ☐ Other (Specify) WVU Memorial Vault 2/2/2010 Morgantown, WV 22. Name and Address of Facility WVU Human Gift Registry 21. Signature of Fureral Service Licensee Box 9131 Morgantown, WV 26506 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ JNG disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 4 Pregnant
9 Unknown 9 Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy After this certificate 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Thesidence 2 11 10 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident
Suicide Investigation Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Within 24 hours after To the Funeral Dir Medical 29a. Certifier Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year)
01/30/2010 D50844 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 912 GOTON PRIVE CUMBIARUND, IND ZISOZ 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ King 29, 2010 Victory Eunice Gibson January 11:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert County Nursing Center Prince Frederick Calvert Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign If Under 1 Year | Jf_Under 24 Hrs. 8. Date of Birth Funeral 1 🗆 M 2 🗓 F Months Hours Min. 218-54-7294 91 Maryland **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director 1 🗆 Yes 2 🗓 No Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? I Hygiene. I children "natural", or items 23a or vent, the Medical Examiner must be i Funeral 5635 Collington Court 20639 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 X No Black, White, etc. à 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 💹 No Specify: Specify: Completed 3 X Widowed 4 □ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) within 7 Elementary/Seconday (0-12) 12 College (1-4 or 5+) homemaker own home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Inportant: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Merle Leon Gibson Anna Elizabeth Swann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Marie King, daughter 10 Little Tree Lane, Owings, MD20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🗓 Other (Specify) entombment Memorial Gardens 02/02/2010 Dunkirk. 22. Name and Address of Facility Rausch Funeral Home, Signature Funeral Service Licenses 8325 Mt. Harmony Lane, Owings, 23a. Part 1. Enter the dise e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, list only one cause on each life. A Approximate Interval Between Onset and Death shock, or heart ailure. List only one cause on e Immediate Cause (Final Physician/ disease or condition resulting in death) nka) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) death certificate be executed and resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FFMA1 F 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Day 1 Yes 2 No the that the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 After this certificate has 1 Yes 2 No Yes 25. Was case referred to medical examiner? the funeral director. Be 26. Place of Death (Check only one) Hospital 2 No 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending work? 1 Natural injury 5 Pending ☐ Accident ☐ Suicide Investigation after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Wurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

10 State

Maryland 21215-0036

Baltimore.

Box 68760

Records,

Division of Vital

DHMH 17 Rev 7/2009

Registrar

29b. Signature and title of certifig

address of

poleted cause of death (Item 23a) (Type, Print)

110 32. Registra s Signature

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Mos

29c. License number

310 Prince Fre

29d. Date signed (Month, Day, Year) 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1 - For State of Maryland / Department of Health and Mental Hygiene Certificate of Death Certificate of Death Reg. No. Certificate of Death Reg. No. Certificate of Death							04067			
	Physicia		1. Decedent's Name (First, Middle, Last) Frederick William Krause,				Jr. Janua					3. Time of Death 6:25 P. M
	Medic Examin		4a. Facility Name (if not institution, give	street and number)		,	4b. City, Town,	or Location of Death		4c.	County of Deat	h
	Funeral		Charlotte Hall V	7. Age	Me (In yrs. last i	birthday)	If Under 1 Year		8. Date of Birt	h	9. Bir	thplace (State or Foreign
	Director		191-09-4907									
	ryland I-f shov ied at	ctor	10a. State 10b. County 10c. City, Town or Location 10d. Inside County MD St. Mary's Charlotte Hall 1 □ Ye						10d. Inside City Limits			
	e filed within 72 hours after death with the Maryland Hygiene. All Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Director	MD St. Ma 10e. Street and Number	ry's	Una	arlot	10f. Zip Code			10g. Citi	izen of What Co	
9800		Funeral	29449 Charlotte					20622			U.S.A.	
		by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏋 Divorced	12. Was Decedent Example Forces? 1 X Yes 2 1 If Yes, Give Year or Dates. 1	No		Vas Decedent of I Yes, specify Cub ☐ Yes 2 💢 No	Hispanic Origin? (Spoan, Mexican, Puerto o Specify:	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, White Specify:	
Baltimore, Maryland 21215-0036		Completed	15. Decedent's Ed (Specify only highest gra	de completed)		(Give k	ent's Usual Occu ind of work done ONOT use retired	during most of work	ing	16b. Ki	nd of Business	Industry
212	iled withir Hygiene other tha ent, the	To Be Co	Elementary/Seconday (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4 or 5-	€	elect	ronics t	echnician			· · · · · · · · · · · · · · · · · · ·	vernment
lano	1 and 2 should be filed if Health and Mental Hy, them 27 is marked oth other traumatic event,		_ ` ' ' '	William	Kraı	use		18. Mother's Nam Anna	e (First, Middle,	Maiden S Add	,	
Mary			19a. Informant's Name/Relationship (Ty		1			t and Number or Run		-	-	•
re,	1 and 2 of Healt item 2		Mark W. Krause,		20b. Place	e of Dispos	sition (Name of natory or other pla	11 Court,	Owings Date	-	20736 ecation - City or	
ti mo	permit. Page 1 a Department of b Important: If ite any injury or of once.	1 70	1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	0 (MD V	etera	ans <u>Ceme</u>	tery 02/0			wnsvill	
Ba	permi Depar Impor any ir	W 18	21 Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736									
f	nysician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/faillytre. List only one cause on each line. Immediate Cause (Final disease or condition) AZHEIMERS DZSEASE Approximate Interval Between Onset and Death Onset and Death									
	Medical Examiner		resulting in death) Due to (or as a consequence of):									
	cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	consequenc	nsequence of):							
		ical Exa	that initiated events resulting in death) Last	c. Due to (or as a	to (or as a consequence of):							
68760	certificate be nding physici use as the bu	/Med	IF FEMALE:	220 If you cutoome o	f prognancy							
. Box	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death: within 24 hours after death: or the Funeral Director. After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as	Completed by Physician/Medical	in the part 12 months 2 1 Live Birth 2 Life Fetal death 3 Life Ectopic pregnancy						23d. Date of d el Month	livery Day Year		
ls, P.O.		ed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute 1 Yes 2 No 3									
Record		Complet	SCHIZO PHRENIA					24a. Was autop perfo 1 Yes	ppsy prior to completion of cause death?		completion of cause of	
/Ital		Be	25. Was case referred to medical examiner? Logital: Log							**		
Division of Vital Records,		Medical Certificate: To	27. Manner of Death Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day,	1 ☐ Inpatient 2 ☐ ER/Outpatient 28a. Date of injury (Month, Day, Year) 28b. Time of injury injury					ow injury	rry).	
			3	28e. Place of Injur	e of Injury - At home, farm, street, factory, office ing, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
			29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							cause(s) and manner stated.		
B	To th To th comp	V	29b. Signature and title of certifier MD				29c. License number 29d. Date				29 · 2010	
Pu	2+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LENA RAO KODALL 14090 H.G. Trueman Rd., #2100, Solomons, MD 20688									
	Stat Registra	e	31. Date filed (Month, Day, Year) B - 1 2010 Server B. Same									

10-00704 Pau

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ul D. Knox		State of Maryland / Depar 1-For State <i>Cert</i> u	tment of H <i>ificate of D</i>		lental H			2010	04068	
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)	Toute of B			2. Date of Deat			3. Time of Death	
edical Exami	ner	Paul Douglas Knox				Month January 24	Day 4, 2010	Year)	1205 hrs	
		4a. Facility Name (if not institution, give street and number)		City, Town, or Local	tion of Death			County of Death		
		Western Maryland Health System Medical Center		umberland	11	To part of Dis		egany	halas (Oh-t-	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. las 218–62–6067 1x M 2 F 57	_		Under 24Hrs Hours Min.	→		Foreig	hplace (State or n untry)Maryland	
à		Usual Residence of Decedent 10a. State							10d. Inside City Limits	
d 10 W 31		MD Allegens Combenland							1 X Yes 2 No	
arylan 8a-f st et onc	cto	10e. Street and Number	10f. Zip Code				Og. Citize	n of What Coun	try?	
ith the Maryland 23a or 28a-f show any notified at once.	Director	417 South Central Ave.		21502		1	USA			
more, MD 21215-0036 gess I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 X No		cedent of Hispanic specify Cuban, Mex			14	4. Race - Americ White, etc.	can Indian, Black,	
after d		Widowed 4 X Divorced If Yes, Give Yaar or Dates:	1 Yes	2 X No spe	ecify:		Sp	^{pecify:} Whi	te	
2 hours afte "natural", Examiner	d by		6a. Decedent's U	sual Occupation (G	Give kind of v	vork done	16b. Kin	d of Business/Ir		
36 n 72 h isan "r	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)				ou)		- 3		
5-0036 led within 7 Hygiene. I other than	E	12 Construction W				(First, Middle, M	ads			
21215-0036 uld be filed within 7/ Mental Hygiene. marked other than c event, the Medical	BeC	Harvey Knox				rgaret :				
212 Ould b Mem mark	10	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Add	ress (Street and		-	_		Zip Code)	
MD 1 2 shoth th and 1 27 is umat		Nikki Winner/Daughter	248 Cen	tennial S	St., F	rostbur	g, MI	D 2153	2	
re, s l an of Hea If iten			ace of Disposition ematory or other p	(Name of cemetery lace)	у,	Date	20c. Loc	cation - City or	Town, State	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.		4 Donation 5 Other Specify: Cour	ntry Sid	e Cremato	ory Ja	n. 28, :	2010	Davids	ville, PA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica		21. Signature of Funeral Service Licensee		and Address of Fa					P.A.	
Physician	\dashv	23a. Part I. Enfer the disease, or complications that caused the death, D		Box 275					Approximate Interval	
> /Medical		failure. List only one cause on each line. Acute alcohol intoxication complicating hypertensive Between Onset and								
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Cardiovascular disease Due to (or as a consequence of): Cardiovascular disease								
		Sequentially list conditions, b								
	Examine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause								
d d	xan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
o, e be executed ysician and burial - transit	al	d.								
e be es ysician burial	edical	UNPENDED 23a,27,28a-f,permE, g901 3/1/10 TT								
Box 6876: death certificate the attending phy		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 Live birth	ncy 2 Fetal de	eath 3 Ed	topic pregna	ncy		Date of delivery onth Date	ay Year	
ox 6 ath cer attendi	sician/N	1 Ves. 3 No.9 Helphourn	n 5 Other	(Specify)						
D. Bo	Phy	Part II. Other significant conditions contributing to death but not rest	Ilting in the under	lving cause given i	n Part I	23e Did to	nacco use	e contribute to the	ne cause of death?	
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and lely filled in by the funeral director, page 2 should be detached for use as the burial - transit	ã	Take Super Signal Section 1997	and and and and and and and and and and	lying cadoo given ii	m arti.		_	_	ably 4 🗸 Unknown	
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COF	ğ		.,.,			autops perforr	ned?	death?	mpletion of cause of	
tal Rection: The certificate ector, page		25. Was case referred to medical		26.Place of De	ath (Check o	1 Yes 2	No	1 🗸 Yes	2 No	
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Division ral or Attendir rs after death al Director: A led in by the fu	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home	e, farm, street, fa	ctory, office building		28f. Location (Street and Number of Rural Route Number City or Town, State) 205 Baltimore Street Cumberland, MD				
Divisospital or A hours after meral Dire	Se	20a Cartifier								
To the Hospital within 24 hours To the Funeral Completely fille	edical	293. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
F S F S	Me	29b. Signature and title of certifier	29c. License number			29d. Date s		te signed (Mont	signed (Month, Day, Year)	
		MAST.		O.C.M.E.				January 25, 2010		
	,	30. Name and address of person who completed cause of death (Item 23		t Daltiman	AD 24204					
	<u>'</u>	Ana Rubio MD. Assistant Medical Examiner 11 31. Date filed (Month, Day, Year) 22. Registrar's Signature		et, baitimore, N	viD 21201					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Helen Udora Kuppy 10:00p M January 25 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Candle Light Cove Easton Talbot 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Hours Months -Days 1 M 2 X F Director 221-12-5769 90 May 18, 1919 Pennsylvania Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at MD Dorchester Cambridge Director 1 ☐Yes 2√∑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5558 Bonnie Brook Road 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours atternent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 ☐No þ Specify Specify: white 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Koble Emma Catherine Singer P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lee Boyce daughter 5558 Bonnie Brook Road, Cambridge, MD permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3X Removal from State 4 Donation 5 Dother (Specify) Sharon Hills Mem. Park 1/28/10 Dover, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 1 700 Locust St., Cambridge, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** nevmo disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-trar Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) detached 1 □Yes 2 No 9 Unknown 9 Linknow Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 ☑ 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an filled in by the funeral director, page 2 2 500 1 □ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital Medical Certification; To 1 ☐ Yes 2√2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 2 and manner stated.

State Registrar 29b. Signature and title of certifile

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ KENDRICK 2127 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 124 Edge Hill <u>Sherwood Forest</u> 8. Date of Birth (Month, Day, Year) Jan . 10 , 1926 Social Security Number 7. Age (In yrs. last birthday, Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Hours Country) Washington, Director 579-26-2451 84 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Examiner must be notified at Director 1 ☐ Yes 2 🏋 No Maryland Anne Arundel Sherwood Forest 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 124 Edge Hill 21405 United States or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Completed by 1 Never Married 2 X Married 1 V Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: Health and Mental Hygiene. tem 27 is marked other than "natural", 3 Divorced WWII White Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Loan Officer Export-Import Bank of US Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earl S. Kendrick Ruth A. Fitton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marianne R. Kendrick/wife 124 Edge Hill, Sherwood Forest, MD 21405 Page 1 and 2 item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 🗆 Burial 2🏋 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Lincoln Crematory 1/21/10 Brentwood, Maryland 22. Name and Address of Facility John M. taylor Funeral Home, Inc. Signature of Funeral Service Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence o **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burnal-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Other (specify) Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death Yes 2 No 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes certificate has been sir irector, page 2 should h 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 28d. Describe how injury occurred injury 5 Pending 1 Yes Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town. State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier se of death (Item 23a) (Type, Print EFENSE HIGHWAY 31. Date filed (Month) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 20° 2010 DONALD F KELLY 9:34 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 640 MECKLENBURG AVE., APT. 219 EASTON TALBOT 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F **Director** 85 156-16-0356 NEW Usual Residence of Decedent 10b. County should be filed within 72 hours after death with the Maryland at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 ☐ No MARYLAND TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 640 MECKLENBURG AVE., APT 219 21601 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 X Yes 2 □ No Black, White, etc. Completed by 1 Never Married 2 Married X Yes Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE "natural", 3 XWidowed 4 □ Divorced Year or Dates Mental Hygiene. narked other than "natura natic event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) CIVIL Elementary/Seconday (0-12) College (1-4 or 5+) 12 ENGINEERING **ENGINEER** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JOSEPH A. KELLY HELEN KUHN if. Page 1 and 2 shou...
if the Health and Mr. if The manual Tism. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN WOROB/STEP-SON 9152 CAMELIA DR., item 2 EASTON, MD 21601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State CHESAPEAKE CREMATION 1/26/2010 CENTER ± 5 1 Burial 2 XCremation 3 Removal from State Important: If any injury or STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM F
200 SOUTH HARRISON ST., EASTON HOME, P.A. Approximate
Interval Between
Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ rla disease or condition resulting in death) Medical Due to Ar as a consequence of: Examine lars Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for القم عم الم Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown After this certificate has been 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of completed filled in by the funeral director, page 2 death? 25. Was case referred to redical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 C Other (Specify) Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Suicide Investigation 24 hours after death Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical

AVYP

within 2 To the I

State

29a. Certifier

(Check

only one 29b. Signature a

22

31. Date filed (Month, Day, Year) JAN 22

30. Name and address of person who complete

lea

Registrar DHMH 17 Rev 7/2009 ed cause of death (Item 23a) (Type, Print)

🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 01-21-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ MARIETTA LANCASTER Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Timonium Baltimore Stella Maris Hospice 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country Carolina 1 □ M 2 F Months Davs Hours Min. (Month, Day, Year) 219-20-6560 82 **Director** Usual Residence of Decedent or items 23a or 28a-f shov Department of Health and Mental Highene. Important if item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director MD. Harford Baldwin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21013 United States 2816 Baldwin Mill Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married be filed within 72 hours after 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 □ Divorced If Yes. Give Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Harford Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria Worker Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Sewel Martin Etta Grimes Lama Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gordon St. 410 Bel Air, Taylor (Daughter West Sharon L. Baltimore, 20a. Method of Disposition 1 Å Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State FEBRUARY Feb. 4 ☐ Donation 5 ☐ Other (Specify) Mem. 2010 Air, Gardens Bel Maryland 22. Name and Address of Facility of Funeral/Service Licensee E.G. Signature & Son Funeral Kurtz Jarrettsville Home arvland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ DEMENTIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to jor as a consequence of Exami that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 LANCASTER attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 9 Unknown the 9 Unknown is certificate has been signed by director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires 2 No Records, Completed 1 Yes 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate ! 1 ☐ Yes 2 ☐ No **Division of Vital** æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 LOther (Specify) HOSPICE 2X No ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 X Natural 5 Pending 2 🗌 No Accident Suicide Investigation Director:

3. Time of Death

10d. Inside City Limits

1 Tes 2 X No

County

Approximate Interval Between Onset and Death

Dav

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2010

within 24 hours a

State Registrar

Medical

29a. Certifier

(Check

6 Could not be

JONES,

DHMH 17 Rev 7/2009

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

TIMONIUM, MD 21093

29c. License number

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2300 DULANEY VALLEY RD.

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February Physician 2010 ear Linda Ruth Lumpkin 8:45 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4340 Huntingtown Road Huntingtown Calvert. If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Ochonth 2ay, 17936 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 53 Days 1 □ M 2 🖫 F 212-68-8248 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be neithed at Director 1 ☐ Yes 21 No Maryland | Calvert Huntingtown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4340 Huntingtown Road 20639 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, If a M any Injury or other traumatic event, If a M any Injury or other traumatic event, If a M any Injury or other traumatic event, If a M any Injury or other traumatic event, If a M any Injury or other traumatic event, If a M any Injury or other traumatic event, If a M any Injury or other traumatic event, If a M any Injury or other traumatic event, If a M any Injury or other traumatic event, If a M any Injury or other traumatic event, If a M any Injury or other traumatic event, If a M any Injury or other traumatic event injury or other event injury or o Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Charles Cleveland Mister, Sr. Lorena Virginia Brady ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Lee Lumpkin - spouse 4340 Huntingtown Rd. Huntingtown MD 20639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Highlands Memorial Port Republic Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home PA 21. Signature of Funeral Service Licensee BRausch 4405 Broomes Island Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** UNG -12MONTH /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and and burial-trar Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 M No
9 ☐ Unknown Month Day 4 Pregnant at time of death 5 Other (specify) the 9 I Inknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 □Yes 2 □ No 2 Accident after death Director: filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

completely To the I within 2 den

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type Print). John Weigel MD Hospital Road Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registraris Signature

FEB

and manner stated.

2010

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year) February 3, 2010

Registrar

29a. Certifier

(Check only

29b. Signature and title of certifier

Medical

DHMH 17 Rev 1/2001

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** William John Kehoe Lewis January 18 2010 12:45 p. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dorchester Mallard Bay Care Center Cambridge If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**M** 2□ F Months Days Hours Director 215-26-4081 Oct. 21, 1930 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2X No MD Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 5002 David Greene Road 21613 USA or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces? 1 ∐Yes 2 XX No 1 ☐ Never Married 2 Married 1 ∏Yes 2KINo If Yes, Give Year or Dates: Specify: þ white Specify: 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed wi f Health and Mental Hygier tem 27 Is marked other th 10 loom operator wire cloth mfg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Lewis Grace Phillips ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other tra once. 5002 David Greene Road, Cambridge, MD Gwen Lewis wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Cemetery 1/22/10 Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner neumonia Sequentially list conditions, any leading to minimize cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed and the burial-tra resulting in death) Last Due to (or as a consequence of): physician Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy ģ in the past 12 months? Day Month Year 5 Other (specify) ed by the a 1 □Yes 2 □ No 9 Unknown 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural 2 Accident To the Hospital or within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

29b. Signature and the of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

32. Registrar's Signature

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

Registrar DHMH 17 Rev 1/2001 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death LUEBBECKE Year 2010 Month 1440 Physician/ HARLES Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner BALTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours Sept. 4, Maryland 1 X M 2 | F **T930** 79 Yrs. 220-26-8179 Director Usual Residence of Decedent 10d. Inside City Limits "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 1 X Yes 2 No St. Michaels <u>Maryland</u> **Talbot** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21663 309 Seymour Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 Yes 2 No Black, White, etc. ş 1 Never Married 2 K Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Ves Give 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) electrical repair electrician Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 27 is marked or r traumatic eve ျ Viva Caulk George W. Luebbecke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 309 Seymour Ave., St. Michaels, MD Ruth Luebbecke/wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1. Department of I Important: If it 1 Burial 2 🔀 Cremation 3 🗆 Removal from State 5 Chesapeake Cremation 1/25/2010 Stevensville, MD 4 ☐ Donation 5 ☐ Other (Specify) Center 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home, P.A.
200 S. Harrison St., Easton, MD 21601 21. Signature of Funeral Service Licensee MERCERON JOHN R 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MULTI ORGAN SYSTEM FAILURE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** SEPSIS. Sequentially list conditions, it any leading to immediate cause. Enter Underlying Examiner Due to or as a consequence of): ROOF 269665. or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CORDINARY RYPASS AND ADRIIC ROOT REPLACEMENT 2008 by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 1 ☐ Yes 2 X No After this certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 1 🖾 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA ည 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To the Hospital o within 24 hours af To the Funeral Di Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 69161 JAN 23,2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 SO GREENE RALTIMORE 21201 LEHR 51 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2010 Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

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	i	Registrar Decedent's Name (First, Middle, La	st)		061	incate or	Death		2. Date of De		100 100 100	3. Ti	ime of Death
Physicia Medic		HOWARD L. LYNG	CH, JR.						Month Linuar	Da	26 201	0	1519 M
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Funeral Director		5. Social Security Number 6. S 221–20–4459	Sex F 7. Ag XIM 2 □ F	e (In yrs. Ia 76	st birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Bir 5—18—1	th 3'33''		rthplace (S GINIA	State or Foreign
rithin 72 hours after ciene. iene. r than "natural", or the Medical Examin	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County DELAWARE SUSSEX 10e. Street and Number 29522 VINES CREE 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Expecify only highest green for the status Elementary/Seconday (0-12) 17. Father's Name (First, Middle, Last) HOWARD L. LYNCH, 19a. Informant's Name/Relationship (1) DUANE C. LYNCH/W. 20a. Method of Disposition 1 Married 20a. Method of Disposition 20a. Method of Disposition 1 Married 20a. Method of Disposition 20a. Method of Disposition 20a. Method of Disposition 1 Married 20a. Method of Disposition 12. Was Decedent If Armed Forces? 1 M Yes 2 If Yes, Give 1 Year or Dates. Iducation ade completed) College (1-4 or 5) SR Type, Print) IFE Removal from State	D Ever in U.S 95 2-1 6+)	16a. Deced (Give k iife. DC BUSINE) 19b. Mailin 29522 ace of Disposemetery, crem GEORG	10f. Zip Code 19939 Vas Decedent of Yes, specify Cu Yes 2 IN ent's Usual Occi ind of work done O NOT use retire SS OWNE g Address (Street VINES sition (Name of latory or other pi E S CEM	Hispanic Oriban, Mexicar No Specify: upation e during mos d) R/OPER 18. Mothe ED et and Number CREEK	XATOR Er's Name Par or Rura RD,	ng Ge (First, Middle, OLLINS I Route Numbe DAGSBO	16b. k CAM Maiden RO, D 20c. L CLA	14. Race - Ame Black, Whit Specify: WH Kind of Business	1 [ountry? erican Indiate, etc. ITE industry ericans Indiate in the indiate in t	ate ELAWARE	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 — Yes 2 — No	c. Due to (or as d	of pregnar	ncy	Ectopic pregna Other (specify)		-			23d. Date of de Month	elivery Day	Year
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7 ∾i ⊗		29b. Signature and title of certifier	ldna		CRM	P R	ise number 900	1100	9		ate signed (Mont		ar)
BA5+1		30. Name and address of person who		*	, , , , , ,		md, a	2180		1	,		
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BA5+1

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Lancaster Physician/ Leslie Eugene 2010 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Easton Talbot at Eastor Memoria If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours Min 1511932 1 X M 2 - F 78 Washington 536-26-6934 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location **Funeral Director** Talbot Easton Maryland 1 Yes 2 XNo 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? 21601 USA 27271 Hayward Trail 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give AirForce Year or Dates Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 X No Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) government mathematician Be 18. Mother's Name (First, Middle, Maiden Surname) Lesive Law Baltimore, Maryland 17. Father's Name (First, Middle, Last) ပ Anna Hliboki Fred Lancaster 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 27271 Hayward Trail, Easton, MD 21601 19a. Informant's Name/Relationship (Type, Print) Elaine Lancaster spouse 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 1 26 10 Hanover, MD Anatomy Gifts Registry 21. Signature of Funeral Service icensee 22 Name and Addre Holloway Funeral Home Professional Association Kalls Rd., Salisbury, MD 21804 ouns. 501 Snow Hill 23a. Part 1. Enter the disease, or carolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Concer Physician, disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Yes 2 No 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 No 1 Anpatient 2 ER/Outpatient 3 DOA မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: 27. Manner of Death 28c. Injury at (Month, Day, Year) work? 1 Anatural 5 Pending Investigation 6 Could not be Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print CASTON 2195 MONTE

State

Registrar

31. Date filed (Month, Day, Year)

JAN 27

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 4 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2^{Day} **Physician** Dorothy C Lawery 10 01 11:50P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hyattsville Prince George's St Thomas More Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days 1 □ M 2 🗓 F 94 05/29/1915 WashingtonDC **Director** 198 01 4255 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ed other than "natural", or items 23a or 28a-f shovevent, the Medical Examinating must be notified as 1X Yes 2 □ No Lanham Director Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20706 USA 6406 Dahlgreen Ct Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes ĀZNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes XXNo Specify: Specify: Black 2 ₩idowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of the and Mental Hygiene.

27 is marked other than "r r traumatic event, professionals." Elementary/Secondary (0-12) College (1-4or 5+) US Government Secretary Δ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 is marked oth any Injury or other traumatic event 2008. Be Bessie Chapman John Daniels 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 311 Cainridge Dr Clarksville, TN 37040 Denise Tucker-granddaughter altimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Rolling Green Mem Pk
2/8/10 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Westchester, PA 22314 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 814 Franklin St Alexandria W Greene FH 23a. Part 1. Enter the disease, or competcations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARTERIOSCUEROTIC CARDIONASCULAR DISEGGO **Physician** YEARN /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cursequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) ed by the detached t 9 Unknown 9 Unknown sate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. Division of Vital Records, þ ilespiraton Failure ventilabir 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed Were autopsy findings available prior to completion of cause of Eaken Malopathy 24a. Was an autopsy nerformed' 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 🖾 No funeral director, 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier TANKARY 25 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BQUEENSNING Rd Hyattsville MD 257 8

Registrar
DHMH 17 Rev 1/2001

(Month, Day, Year)

10-00998

Terrance Todd Lloyd

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State of Maryland / Department of Health and Mental Hygiene	2	10	\cap	1. 1	2)
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Imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Reath and Mental Hygiene. Itani: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Director	25485 M		y Road					1719						ates
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Division of Vital Records, P.O. Box 68 tal or Attending Physician: The law requires that the death certificate death. al Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as	ᅙ										1 Ye	s 2 🗸	No 3	Proba	ably 4 Unknown
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Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	(Check only		nysician: To the beaminer:On the basis	of examinati	-									
To Your	Š	29b. Signature and	title of certifie	and manner s	A A n	Out		29c. License	e number		·	29d. Da	ate signed	d (Mon	th, Day, Year)
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene 🚄 U 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 29 3. Time of Death 9:35 a^M DOLORES FULTON MAGNESS JANUARY 2010 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 32 Charles Lane Cecil Warwick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex Months Days 1 M 2 F 1926 217-22-1897 83 17 Nov Michigan Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 XNo Cecil Warwick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32 Charles Lane 21912 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? 1 GYes 2 No 1952 1 De Yes 2 No 195 If Yes, Give Year or Dates: -1956 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify. White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Registered Nurse</u> State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Magness Verna Fulton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret S. Jeanes (cousin) 32 Charles Lane Warwick, MD. 21912 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Angel Hill Cem. 2/4/2010 Havre de Grace, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign - re of Funeral Service Licensee 22. Name and Address of Facility
Galena Funeral Home of Stephen L Schaech M00510 Galena, 118 West Cross St. 21635 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Monic YEWS 0 disease or condition resulting in death) Due to (or as a consequence of): Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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MD

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examination and the routified at once.

Baltimore, Maryland 21215-0036

Examine Physician/Medical \$ Completed page 2 Be

law requires that the death certificate be executed

Box 68760

P.O.

Records,

Division of Vital

Physician:

g physician and is the burial-transit attending ph for use as the signed by the a I be detached for ate has certific 25. Was case referred to medical Certification: To After this funeral c 27. Manner of Death filled in by the

To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely State Registrar

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Tyes 2 No 9 Unknown

5 Pending investigation

6 Could not be determined

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a Was an

autopsy 1 ☐ Yes 2 🗹 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Beth Α. Renzulli M.D. 212 Carter Dr. Suite A. Middletown, DE.

29c. License number

00060425

31. Date filed (Month, Day, Year) FEB 17

29b. Signature and title of certifier

examiner's

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

1∐Yes 2 No

32. Registrar's Signature

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2 **Physician** JUANITA MATTHEWS FEBRUARY 2010 LEE 4:15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** Chester River Manor Chestertown Kent If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 23 1 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 ▼ F Months Yrs. 1937 Maryland Director 220-32-8444 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 28a-f show or than "natural", or items 23a or 28a-f show the Medical Examinal in ust be notified at 1 ☐ Yes 2 No Director MD Oueen Anne's Sudlersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1316 Millington Rd. 21668 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 □Yes 2 No Specify: Completed by White Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Linwood Matthews ည Madge Kelley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (friend) 319 Perry Lynch Rd. Millington, MD. 21651 Donna Usilton 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2/9/10 Galena, MD. Galena Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun ral Service acens e 22. Name and Address of Facility Galena Funeral Home of Stephen L. Schaech 118 West Cross St. Galena, MD. 21635 M00510 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** COPD /Medical Due to (or as a consequence of): Examiner Dehy location Due to (or as I consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 No Day Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> GOUT, GERD, Depression, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 sl coronary disease, Apric mennysm 2 □No 1 ☐ Yes 1 🗆 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours after e Funeral Dire pletely filled in b certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2: To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0051735

150

State Registrar 6602 Church Hill Rd. Chestertown, MD. 21620

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signatu

Frederick Delboy,

31. Date filed (Month, Day, Year,

FEB 1 7 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2-4-2010 Day **Physician** Mary Jane Millan 8:47 A^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Kline Hospice House Mt. Airv Frederick 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min 1 □ M 2 🕅 F 226-22-1222 87 Director 1-29-1923 MD Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10d. Inside City Limits show 10c City Town or Location 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Exeminar is ust be notified at Director 1 XYes 2 □ No Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 Sandstone Drive Apt 205 21701 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: ⋧ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed withli Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Inc. M. College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Harold McVav Agnes Hartman ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Dinkel Daughter 7101 Crystal Court Middletown, MD 21769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 2-8-2010 Smithsburg, Maryland 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Se M01176 106 East Church Street Frederick, MD 21701 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each time. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 0445 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): burial-Box 68760 attending physician for use as the buria Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.0. 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed' certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. n 24 hours after death. le Funeral Director; A bletely filled in by the fu 2 ☐ Accident 1 ☐ Yes 2 🗆 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of Das 61410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GERN (LIEM 258) (TYPE, PRINT)
801 TOLL HOUSE, FREDERICK, MI) 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

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Frederick

State Registrar

Medical

29a. Certifier (Check

only one) 29b. Signature and

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar s Signatule

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ ROHANN, MICHAEL 0% Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MARYUAND MEDICAL CONTER BALTIMORE university of If Under Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** May 11, Year) 24 1 □ M 2 🗓 F Months Days Hours Min. Maryland Director 220-80-6203 85 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location Director Maryland Frederick Smithsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21783 13224 Wolfsville Road USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 X Married 2 X No 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: White Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hi Important: If item 27 is marked oth any injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ralph Emerson Morgan Edith Brandenburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grayson J. Michael/husband 13224 Wolfsville Road, Smithsburg, Maryland 21783 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Mark's Lutheran 4 Donation 5 Other (Specify) Feb.11,2010 Wolfsville, Maryland ice Licensee 21. Signature of Funer 504 Main Street 22. Name and Address of Facility Ricketts Funeral Home Myersville, MD 21773 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ NON ST-ELEVATION MYOCARDIAL INFARCTION disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir physician and the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending phore as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) ned by the a e detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe 1 Yes 2 No Yes 2 Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 잂 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Physicial 24 hours after death.
To the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a, Certifiei 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and titlen of certifier M.D.

AM

6:01

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

Year

2010

1 ☐ Yes 2X No

68760 Box P.O. Records, **Division of Vital**

Registrar DHMH 17 Rev 7/2009

State

ELTAKI, M.D. 22 S. GREENE ST, BALTIMORE, MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

1104088772

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** George M. Morin JANUAR 31,2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cheverk Trince George's Hospital 5. Social Security Number 6. Sex If Under 1 Year | If Onder 24 Hrs. 8. Date of Birth (Month, Day, June 24, 1948 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Hours Min. New York Months Days 091-38-3390 1 M 2 □ F 61 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show South ed other than "natural", or Items 23a or 28a-f showere, the Medical Examinar mast be rutilled at 1X Yes 2 □ No Director Carolina Anderson Anderson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 513 Mildred Street 29621 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No White Specify: þ Specify: 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Health and Mental Hygiene.
em 27 ls marked other than
ther traumatic event, Ine III College (1-4or 5+) Truck Driver Truck Driving Trade shows 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George M. Morin Else M. Finnie ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Morin -wife 513 Mildred Street Anderson, S.C. 29621 permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 2/1/2010 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final theroseferotic **Physician** Cardeo VASCe disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) ب Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. s Funeral Director: After this certificate has been signed by the attending abused and attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 ☐ Pregnant at time of death 5 Other (specify) nis certificate has been signed by the director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 ☐ Yes 2 ☐ No 3☐ Probably 4☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 □ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

88

10-00892 Debbie A. Mosse		Please Type or Print in Black Indelibl State of Maryland / Departmen	t of Health and Mental H		gible. 2010	0408
		Registrar	e of Death		g. No.	
Physicia Medical Exami	ın/ ner	1. Decedent's Name (First, Middle,Last) Debbie Ann Moss	er	2. Date of Death Month January 31	Day Year	ime of Death 452 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Death	
		Western Maryland Regional Medical Center	Cumberland		Allegany	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months Days Hours Mir	_	h(MM/DD/YYYY) 9. Birthplac Foreign . 1963 Country	,
		214-62-3883 1 M 2 X F 46	Yrs.	Apr 10	, 1903 country	UID .
nd show any	_	MD Allegany 10c. City, Town or I C	orriganville			Inside City Limits Yes 2 X No
the Maryla a or 28a-f	Director	10e. Street and Number 10910 Lapp Lane	10f. Zip Code 21524	10	g. Citizen of What Country?	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced of Section 1.5 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto Yes 2 X No specify:		14. Race - American In White, etc. Specify: White	ndian, Black,
hours afte	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Education (Specify only highest grade completed)	edent's Usual Occupation (Give kind of ng most of working life, DO NOT use ret		16b. Kind of Business/Indust	ry
0036 within 72 Pene. er than "r	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	riatric Nursing Assis	stant	Hospital	
215-(be filed v ntal Hygi rked oth	Be C	17. Father's Name (First, Middle, Last) Ronald Barnes, Sr.	Marg	· ·	mpson) Barnes	
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medica	ို	19a. Informant's Name/Relationship (Type, Print) David Mosser Husband	ailing Address (Street and Number or 10910 Lapp Lane	Rural Route Numl	ber, City or Town, State, Zip (Triganville M	D 21524
Baltimore, permit. Pages I am Department of Heal Important: If iten		1 Burial 2 Cremation 3 Removal from State crematory	sposition (Name of cemetery, or other place) Christian Cemetery	Date 2/7/2010	20c. Location - City or Town Artemas	, State PA
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/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	ion		Бе	tween Onset and Death
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.				
	nine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
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Reco The lav cate has	Ē			perform 1 Y Yes 2	ned? death?	2 No
Vital Rec ysician; The his certificate director, page	8	25. Was case referred to medical examiner? Hospital: 1 Inpution 2 M EP/Outpo	26.Place of Death (Check tient 3 DOA Other Nursin			
n of Vi ding Physi I. After this funeral din	라	1 Ves 2 No Prospital 1 Inpatient 2 VER/Outpa 27. Manner of Death 28a. Date of Injury 28b. Time			Residence 6 Other:	
lon C tending eath. or: Af	틽	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation Fd 1/31/10 Fd 1:		unk	, ,	
Division of Vital Records, P.O. pital or Attending Physician: The law requires that thours after death. reral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach	Certification:	3 Suicide 6 X Could not be determined (Coecifu) house	street, factory, office building, etc.	28f. Location (St or Town, Sta	reet and Number or Rural Roate) 10910 Lapp	ute Number, City Lane
Hospi 24 hou Funer etely fil	ledical Ce	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or inves	occurred at the time, date and place, and		(s) and manner as stated	se(s)
To the within To the compl	Medi	and manner stated 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Di	
		nus D	O.C.M.E.		February 1, 2010	

State 31 Date filed (Month, Day Year)
Registrar FEB 1 7 2010

Ana Rubio MD.

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Marylan					/giene		
Aı	mended		m State #8, per F. Ho		Cer	rtificate of	Death		Reg. No. 2	10,01	1089
M	Physicia		Decedent's Name (First, Middle, Last)					2. Date of D Month	Day	Year 3. Time	or Death
4	/Medic		GEORGE R. McEI 4a. Facility Name (If not institution, give s	WAIN, SR.		4b. City, Town, o	r Location of I	Feb.	1, 201	ty of Death)5AM ^M
~	Examin	er	Hartley Hall N		е	Pocomo				ester	
	Funeral		5. Social Security Number 6. Sex		last birthday)	If Under 1 Year Months Days	If Under 24	-	rth year)929	9. Birthplace (Sta Country)	te or Foreign
	Director			M 2□F 80	Yrs.	Working Days	riodis	Apr.	23, 19	23 PA	
	and w t		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside	e City Limits
	Maryl: f sho ied at	힏	VA Accomack	Cro	onhac	kville				1 □ Y	res 2 No
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	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show ideal Examiner must be notified at	Funeral Director	11. Wanta Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	lispanic Origii an, Mexican,	n? (Specify Yes or N Puerto Rican, etc.)	o- 14. Ra Bla	ace - American Indian ack, White, etc.	,
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 TYes 2 □ No If Yes, Give Year or Dates:	1:	¹□Yes XX No	Specify:		Speci	White	
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pu	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)	rrain				s Name <i>(First, Middl</i> pelle Ch		· ·	
ryla	d Mer narke natic	ို	Charles E. McEl 19a. Informant's Name/Relationship (Ty		10h Mailir	ng Address (Street	L	or Rural Route Num			
Maryland 21215-0036	id 2 sl ith an 27 is r traur		Martha McElwain		1				-	backvill	e, VA
ē,	ss 1 and 2 of Health a item 27 is other trau		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of matory or other pla	ce)	Date	20c. Location	ı - City or Town, State	·
E O	Page nent o nt: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State		renatory		/2/2010	Salis	bury, MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens	ee		2. Name and Addre		405		Pocanol	ke,
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<u>ح</u>		Completed						pei 1∐ Yes	formed? 2 No	death? 1 ☐ Yes 2 ☑ Mo	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		_ lou		of Death (Check only			
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	To the Hospital or within 24 hours after To the Funeral Directory (Completely filled in b		(Check only 2 Medical Exami	sician: To the best of my kno iner: On the basis of examina							ıse(s)
	To the I within 24 To the I complet	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number		29d. Date sign	ned (Month, Day, Yea	ar)
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			30. Name and address of person who co	ompleted cause of death (Iter	m 23a) (Type,				, ,		
L	3A5+1	8 8	STARAD R SATY			RICET ST	POCON	OKE GTY	MD 2	21851	1
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2 Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) January 34, 2010 E120 John Wayne McKnett 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince Frederick Calvert Calvert Memorial Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Allenth, Day, 109784 Days Min 75 1 ☑ M 2 ☐ F 579-42-6037 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 ☐ Yes 2 🖾 No St. Leonard Maryland Calvert 10g. Citizen of What Country? United States 10f. Zip Code 10e. Street and Number 20685 1815 Highland Drive 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ⊒Yes 2 □ No If Yes, Give korea Year or Dates: 1 ☐ Never Married 2 Married Specify: white 1 ☐ Yes 2 🙀 No Specify. 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Columbia LNG plant master electrician 18. Mother's Name *(First, Middle, Maiden Surname)* Marion Elizabeth Fawthorp 17. Father's Name (First, Middle, Last) JOhn Wesley McKnett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1815 Highland Drive St. Leonard, MD 20685 Patricia A. McKnett- wife 2010. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) February 2, Metropolitan runeral Service, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Alexandria Virginia 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home PA 20676 10 4405 Broomes Is. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 □No 1 ☐Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊈Yes 2∐No 1 ☐ Inpatient 2 【 ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Physician /Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 l. Department of health and Mental Hygiene. Important: If them 27 is marked other than "naturany injury or other traumatic event."

Physician

/Medical

Examiner

attending physician and for use as the burial-tran

cate has been signed by the page 2 should be detached

certificate

After this

funeral director,

Physician/Medical

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Be Completed

Certification: To

Medical

29a. Certifier

(Check only

29b. Signature and time of certifie

72 hours after death with

3altimore, Maryland 21215-0036

i 24 hours after death, e Funeral Director: Aff letely filled in by the fur filled in by To the ! within 2 To the F 10+1

State

Registrar

Frederick 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Walled

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Adoracion Physician/ Α. Morac January 22, 2010 7:30 p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Montgomery Hospice-Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last hirthday) 8. Date of Birth Days Hours Min. 226-11-3012 1 M 2 X 60 April 15, Year 1949 Philippines Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20902 USA 3817 Woodridge Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Asian 1 ☐ Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Executive Assistant World Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Augustin J. Autea Esperanza K. Paz other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3817 Woodridge Avenue, Silver Spring, MD 20902 Santiago D. Morao/Husband Baltimore, 1 Date 30, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o Jan. 2010 1 Durial 2 X Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Francis d'Addres pissilly Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Lung Cancer with Metastasis Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to for as a consequence of, nding physician and use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ate has been signed by the atte page 2 should be detached for in the past 12 months? Month Day Year Pregnant at time of death Yes 2 x No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed' After this certificate 2 No Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 24 No. Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Hospice 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🏝 Natural injury work? 1 ☐ Yes 2 ☐ No. 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD33755 January 22, 2010 iD

State Registrar 30. Name and address of pe Bindu Joseph,

31. Date filed (Month, Day, Year)

JAN 2 5 2010

son who completed cause of death (Item 23a) (Type, Print)
MD 1355 Piccard Drive, Rockville, MD 20850

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** A^M 24, 9:40 2010 January Alta Nadine Miller /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick Mount Airy
If Under 1 Year | If Under 24 Hrs. Kline Hospice House Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, **Funeral** Days Hours Min. 1 □ M 2 🗓 F 74 Dec. 1935 Tennessee 214-30-2180 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ortant: If item 27 is marked other than "natural" or items 23a or 28a-f show Injury or other traumatic event, Ite Medical Examinar must be redified at 1 ☐ Yes 🎾 No Director Maryland Frederick Monrovia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21770 Funeral 4533B Lynn Burke Road filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. Specify: ģ White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Food Service Manager Nursing Facility 12 should be filed with and Mental Hygier 7 is marked other tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lassie Mae Edens ၉ Willard Ralph Sexton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a Brenda Conners, daughter 4533B Lynn Burke Road, Monrovia, Maryland 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or Metropolitan Crematory 1/25/2010 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Molesworth-Williams Funeral Home 20872 26401 Ridge Road, Damascus, Maryland yan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Yoo

9 Unknown Month Day Year 5 ☐ Other (specify) P.0. the detached 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be 6 Nother (Specify) examiner? 2 Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA HOUSE Certification: To this 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Mapner of Death After t To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certi 30. Name and address of person who completed cayse of death (Item 23a) (Type, Print) MD 300 West Ninth Street, Frederick, Maryland 32 Registrars Signature Robert L. Kaufmann, 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 28f per me, g900,02/22/2010dhb

Gertificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Thelma Clara Morton 1525 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ALLEGANY WMRMC UMBERLAND Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F Months Days Hours Min (Month, Day, Year) October 03, 1913 Country) Maryland Director 217-66-9466 96 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Lonaconing Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral **USA** 57 Jackson Street 21539 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Margaret Stephens David Yates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patty Morton- Daughter-in-Law 15655 Lower George's Creek Road, Lonaconing, Maryland, 21539 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date February 0 cemetery, crematory or other place) 1 ▲Burial 2 ☐ Cremation 3 ☐ Removal from State Frostburg, Maryland Frostburg Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2010 Signature of Funeral Service Licenses 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A Brand Juhom 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line ORDNI Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Esquentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and ned for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown signed by t Id be detach P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, icate has been sig r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 \(\subseteq \text{Yes} \) 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending Valuial 2 X Accident 8:00p 01/30/2010 2X No Patient Fell Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Nursing Home 28f. Location (Street and Number or Rural Route Number, City or Town, State) 57 Jackson St. Lonaconing, MD determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 26907 12010

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

FFR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 27, 2010 9:45 M Phyllis Regina McKenzie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 62 Jackson Street Allegany Lonaconing 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) 6. Sex Funeral 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 ☐ M 2 👿 F 188-22-1049 Director July 26, 1928 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Executions and the rediffed at Yes 2 □ No Director Lonaconing Allegany Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 62 Jackson Street 21539 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 No <u>ک</u> Specify. Specify: 3 Widowed 4 □ Divorced White Completed 7 is marked other than "natur traumatic event, the "sedical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Human Resources** 12 Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell Lambert Clara Jane Clark မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if of Health a Mitchael McKenzie - Son 62 Jackson Street, Lonaconing, Maryland, 21539 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date February 02 Department of Important; If it any injury or o once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Westernport, Maryland Duckworth Cemetery 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CoRonan disease or condition resulting in death) 12cm 5 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by willatus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 After this certificate has autopsy No 1 □ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 212No Certification: To 1∏Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 → Natural 2 □ Accident 5 Pending investigation ours after death.

neral Director; A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Tip Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 021242 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JAN 2 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Morg 2010 :150 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARYS 15altimore Lexiner ton Kark hore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Vear If Under 24 Hrs. Date of Birth (Month, Day, Year) 9. Birthplace Country) ce (State or Foreign **Funeral** 68 Months Days Hours Min. 1 2 M 2 □ F 220-40-3713 Yrs. **Director** -20-Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Parlo 1 Yes 2 No Director Marys 54. MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 4583 20653 ITIMUIC Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Mayes 2 No 1964 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 XYes 2 ☐ I If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Federal Elementary/Secondary (0-12) College (1-4or 5+) Grounds 12 Guern 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John ပ ヒる 19b. Mailing Address (Street and Number or Tural Route Number, City or To n, State, Zip Code) 19a. Informant's Name/Relationship (Type. Pri t) VA exAndria 20b. Place of Disposition Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 28-2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funderal Service Licens 22. Name and Address of Facility 20608 23a. Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. App oximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ned by the a 1 ☐ Yes 2 ☐ No 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 00 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Leunardtown

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Su. le 205,

40900 Merch

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ J_{an}^{Month} 21,2010 Thomas Ε. Milner 16:41 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🙀 M 2 🗆 Hours 57 California 553 86 6815 Director 1952 March Usual Residence of Decedent Fshow 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Tes 2 No 28a-f Maryland Charles Waldorf, 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? , or items 23a Funeral 2505 Charter Oak Drive 20735 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 M Married \$ X Yes 2 ☐ No f Yes, Give 1 O Baltimore, Maryland 21215-0036 1 ☐ Yes 2 V No Specify: "natural", IT Yes, Give Year or Dates. 1976–1988 Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life, DO NOT use retired)
Test Operator 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. the Federal Government Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental II, Important: If item 27 is marked oth any injury or other traumatic even any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ည Doris Opal Evans Richard Siles Milner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chong Yo Milner (Wife) <u> 2505 Charter Oak Drive, Waldorf, MD</u> 20601 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State race of Disposition (Name of cemetery, crematory or other place)

Jain 28, Da@010 20b. Place of Disposition (Name of 20c. Location - City or Town, State Cheltenham, Maryland 4 Donation 5 Other (Specify) Maryland Veterans Cemetery Sign two of Funer I Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. the attending physician and thed for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 L g Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.3 autopsy performed?

Yes 2 No death? 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospita 힏 Other: 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner eath Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide
Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nusse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year 1:10 PM Ernest D. Maier Medical 010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BATIMORE WASHINGTON MEDC ANNE ARUNDER BURKER 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 X M 2 🗆 F Months Hours Min. 2/20/1930 Maryland Director 220-26-4926 79 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and the files 23a or 28a-f show ant if item 27; is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21401 1705 Westminster Way USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 XMarried Completed by 1 Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Block and Elementary/Seconday (0-12) 12th College (1-4 or 5+) Co-Owner Building Materials Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ernest Maier Elseba Pullman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty L. Maier/ Wife 1705 Westminster Way, Annapolis, MD 21401 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or Lakemont Cemetery 4 Donation 5 Other (Specify) 1/25/10 Davidsonville, MD Signatur of Funeral Service Lig 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) NG Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) by the attending physician and tached for use as the burial-transit executed Jause (Disease or impury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 9 Unknown npleted filled in by the funeral director, page 2 should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 은 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?

1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Tertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Defining righting righting the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar 29b. Signature and title of certifier

TEORGE

31. Date filed (Month

roun

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

0059190

301 HOSPGAL BORNE

29d. Date signed (Month. Dav. Year)

ELEN BURNIE

20,2010

mo26661

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Helen Marie Morris 25,2010 Jan. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Salisbu If Under 2 Salisbury Rehabilitation Nursing Ctr. 5. Social Security Number 6. Sex 7. Age (In yranast birthday) Wicomico **Funeral** Days Min. Months Hours 06/21/1913 1 □ M 2**X** F 96 216-80-3644 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State ortant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at Snow Hill Director Worcester Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21863 USA 6903 Disharoon Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🙀 No Specify. Completed by 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) farmer agriculture 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be of Health and Mental Pages 1 and 2 should be Sarah Elizabeth Figgs Clarence C. Twigg ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4296 Ramblin Rd., Salisbury, MD 21804 Linda Ellis|niece 3altimore, 20h Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Itel any Injury or ott Battes Mellior Ial Perplace) 1 Burial 2 □ Cremation 3 □ Removal from State 1|30|10 Snow Hill, MD Methodist Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Holloway Funeral Hosol Snow Hill Rd., Home Professional Associaiton Kott Ra 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 2700 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 0-Due to (or as a consequence of) Physician/Medical Examiner law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 I Inknown 23e. Did tobacco use contribute to the cause of death? signed by the period of the period of the details and the details are the period of th Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy page nerformed' or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: Other: 4 Invursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2/1/10 1 Inpatient 2 ER/Outpatient 3 DOA ပ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation 1 ☐ Yes 2 No or ... s after dec. •al Director: A 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled in Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) within 2. and manner stated To the h 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Year

Black, White, etc.

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

ear

4 □Unknown

3 Probably

1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

2□ No

1 ☐ Yes 2 X No

Maryland

white

State Registrar DHMH 17 Rev 1/2001

W.D egistrar's Signatu ic Ave

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William H. Robi

JAN 28

31. Date filed (Month, Day, Year)

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			1- For State Registrar		Certi	ficate of	Death				Reg. N	o. 2U	1	04101
Med	Physici lical Exami		1. Decedent's Name (First, Midd Patricia Anne M							2. Date of D Month	Day	Year		Time of Death 1422 hrs
er"	noar Exam		4a. Facility Name (if not institution	on, give street and n	umber)	4	o. City, Town	n, or Le	ocation of Death	Februar		4c. County of	Death	
Н			14404 Long Channel	Circle			Germani	town				Montgom	ery	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last	t birthday)	If Under 1		If Under 24Hrs.	_	Birth(MI	M/DD/YYYY)	9. Bir Foreig	thplace (State or
	Director		114-50-0441	1 M 2 F	48	Yrs.	Months	Days	Hours Min.	June	28.			^{untry)} New Yorl
	,		Usual Residence of Decedent							10 0110				
	ow any		10a. State 10b. County		10c. City, Te	own or Location	n							10d. Inside City Limits 1 Yes 2 X No
and the second	yland -f shc once	tor	Maryland Montgo	omery	Germa	ntown	10f. Zip Cod	4-			140- 0	itizen of Wha		
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No.	vith th s 23a	eral	14404 Long Char		e cedent Ever in U.S.		20874 Decedent of	f Hispa	anic Origin? (Sp	ecify Yes or	USA No-	14 Race -	Ameri	can Indian, Black,
0	eath v item ust b	nue	1 Never Married 2 M						Mexican, Puerto			White,		,
45	after d	by F	3 Widowed 4 X Div	orced If Yes, Give Ye	ar 1979–80	1	Yes 2X	No	specify:			Specify: V	Vhi	te
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	21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	Thomas Mathhew					_	N	۹.		,		
	213 ould b d Men s mar-	To	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailing	Address (S	Street	and Number or R	LS CT OII	lumber,	City or Town,	State	Zip Code) 07712
	MD id 2 shouth and m 27 is sumati		Theresa Durso,	sister		32 Lar	bert	Joh	nson Dr		lavs	ide. N	ew	Iercev
	s l an f Hea		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal f		ice of Disposit matory or othe		f ceme	etery,	Date	200	. Location - C	city or	Town, State
	Page Page nent c		4 Donation 5 Other S			Souls (Cemete	ry		8,201		ermant	owi	. Maryland
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee	15	22. Na	me and Add	lress o	of FacilityMo1e	swortl	n-Wi	11iams	Fu	neral Home
			23a. Part I. Enter the disease, or	complications that of	CACAMA Death D	264	Ol Rid	lge	Road, D	amascı	ıs.	Marvla	nd	20872 Approximate Interval
	Physician /Medical		failure. List only one cause	on each line.	tensive c					respiratory a	an est, s	riock, or riear		Between Onset and Death
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		iner	if any, leading to immediate Due to (or as a consequence of): Tausa Finter Underlying Causa C											
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	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	- 1		d										
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	876 ificate	cian/Medica	IF FEMALE: 23b, Was decedent pregnant in th	23c. If yes,	outcome of pregnar		l death	3	Ectopic pregnar	ncv	2	3d. Date of de Month		ay Year
	ox 687 eath certific attending	Sign	past 12 months?	4 Pregr	nant at time of death		r (Specify)			,	4			
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	tal Rec tian: The l certificate l ector, page	悥								1 ✔ Yes			∕ Ye	s 2 No
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	Division of Vital Records, P.O. Box 68760, ral or Attending Physician: The law requires that the death certificate be as after death. "I Director: After this certificate has been signed by the attending physic led in by the funeral director, page 2 should be detached for use as the bur	ြ	1 Yes 2 No	'		R/Outpatient Bb. Time of Inj			- I I I I I I I I I I I I I I I I I I I	Home 5		dence 6		Scene
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	To the Hos within 24 h To the Fun completely	Medical	2	miner: On the basis and manner s		or investigatio				the time, da				
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			Ullet				Ü.	.C.M.	. C.		⊢e	bruary 4, 2	2010	
			30 Name and address of person Ana Rubio MD. Ass	who completed causestant Medical			eet Balti	imore	e, MD 21201					
		ate		32 Re	egistrar's Signature	Carlotter and American	F-100		, Z 1201					
	Regist	rar	31 Date filed (Month, Day, Year)	2010 /2	un a	Dark								

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Donald Edward Newell : DGAM -2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1592 St. Margaret's Road Annapolis Anne Arundel 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 🔀 M 2 🗆 F 213-22-0511 Director 12/24/1927 82 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits al", or items 23a or 28a-f show Examiner must be notified at Director 1 ☐Yes 2 ☑ No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1592 St. Margaret's Road 21409 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Ye ar or Dates: WWI] Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☑ Married , o. Baltimore, Maryland 21215-0036 1 □Yes 2X No White Specify þ WWIT Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", Completed er than "natur 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ith and Mental Hygier

7 is marked other the traumatic event, the Home Builder Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Newell Harriett Fisher ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Helen K. Newell - Wife 1592 St. Margaret's Rd, Annapolis, MD 21409 or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ē Department of Important: If it any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 1/27/2010 Baltimore, MD 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licenses Merilia 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ougestive disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner P-1050 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner as a consequence of): law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Year Dav 5 Other (specify) P.O. ed by the a detached f 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ⋧ icate has been siç 7, page 2 should b Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 □ No 1∐Yes 2DXNo director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 5 ☐ Pending investigation 1 Natural Injury 1 □Yes 2 □No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year,

State Registrar 30. Name and address of person

31. Date filed (Month

Lille, I oth, Day, Year) JAN 26 TREWISTER

who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mary		epartme Certifica			nd Menta	l Hygie Reg.	2111	0 0410)2
	Physici	ian	1. Decedent's Name (First, Middle, Last)	_					2. Date Mor		Day Yea		ath
	/Medi	cal	Nina 4a. Facility Name (If not institution, give si	B.		Nic		Location of	Dogsth 1		31 201 4c. County of D	3.03	- M
	Examir	ner	143 Francis Drive	reet and namber)		40.00	Salis		Deali		Wicon		
	Funeral		5. Social Security Number 6. Sex		yrs. last birth		er 1 Year	If Under 24		e of Birth	9 1	Birthplace (State or Fo	reign
	Director		235-86-8483	M 2X F 10	0 Y	rs. Months	Days	Hours		nth, Day, Ye -1909	We	country) st Virgini	La
	and		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town	or Location						10d. Inside City Li	imite
	Marylan f show	ō										1X Yes 2	
	the 128a	rect	MD Wicomico 10e. Street and Number		Salis		p Code			10g.	Citizen of What		
	ath with the Mary s 23a or 28a-f sh	Funeral Director	143 Francis Drive					804		1.23	USA		
	death	ner		2. Was Decedent Ever	in U.S.	13. Was Dec			in? (Specify Yes Puerto Rican, e	s or No-	14. Race - A	merican Indian,	
36	after or ite	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □Yes 2 X No If Yes, Give		ir ves, sp 1 □ Yes		n, iviexican, i Specify:	Puerto Hican, e	etc.)	Black, Wi		
ő	72 hours after death with the Maryland natural", or items 23a or 28a-f show	d by	3	Year or Dates:									
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212	withi jiene. r thar	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Homemak		,			Own Home	2	
b	al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)					18. Mother's	s Name (First, I	Middle, Maid	en Surname)		
/lai	uld bu Menta Irked	10	John Dixey	N	AcGrady	У		Rhoda		Ann	Во	owman	
Maryland 21215-0036	2 sho and sums		19a. Informant's Name/Relationship (Type	e. Print)							y or Town, State		
	and lealth m 27 her to		Mona Farley - Daug					rive,			aryland		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Erominer once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☒ Re	moval from State	cemetery,	Disposition (Na crematory or	other place		Date		Location - City		
Itim	it. Pa rtmer rtant njury		4 □ Donation 5 □ Other (Specify)		Lue Rio	dge Men			-6-2010			West Virgin	nia
Ba	permi Depa Impo any ir		21. Signature of Funeral Service Licensee	us Roxb	0						ral Home		
	_		23a. Par 1. Enter the disease, or compline	ations that caused the	death. Do no						y, mary	Land 21804 Approximate Interval Between	_
	Physician Example Physician Physicia	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Il any leafly to Final Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	n equence of		ar	LEST				Onset and Death		
P.O. Box 68	t the death certif by the attending ached for use as	Physician/Medi	in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pri 1 Live birth 2 4 4 Pregnant at time 9 Unknown	Fetal death of death	3 ☐ Ectopic 5 ☐ Other (s	pecify)				23d. Date of o	Day Year	
Records,	uires tha signed d be det	Completed by	Part II. Other significant conditions contr	ibuting to death but not	resulting in t	he underlying	cause give	n in Part I,	23e	. Did tobacc 1 Yes		to the cause of death Probably 4	
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Re	The lar	Ę.							^{24a}	autopsy performed/	prior t	autopsy findings availa o completion of cause ?	
ta	sician: The certificate rector, pag	au I	25. Was case referred to medical	 _		-		26 Place of	1 □ f Death (Check	Yes 2 5	No 1 □ Y	es 2 ANo	
of Vital	di isi	5 B	examiner?	spital:	2 🗆 ER/Outp	atient 3 D	OA Othe	r-	' -	4	6 ☐Other (Si	necify)	
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sio	Vttendi death. ctor: A y the ft	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			М	1 🗆 Y	′es 2 □ No)				
Division	or At after of Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm pec <i>ify)</i>	i, street, factor	y, office			ation (Street or Town, Sta		Rural Route Number,	
	Hospital 24 hours a Funeral I tely filled	2	29a. Certifier Physic	clan: To the best of my	knowledge	death occurre	at the tim	ne date and	place and due	to the cause	(e) and mannor	as stated	
	e Hos 124 h e Fur letely	edical	(Check only 2 Medical Examine one)	r: On the basis of exar and manner stated.	mination and/	or investigatio	n, in my op	pinion, death	occurred at the	time, date a	ind place, and d	ue to the cause(s)	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Me	29b. Signature and little of certifier			29	c. License	number		29d. I	Date signed (Mo	nth, Day, Year)	
			tony 1 kg	ner. Ph	0 CF	NY /	20	000	13	02	10112	010	
			30. Name and address of person who com	pleted cause of death ((Item 23a) (Ty	/pe, Print)			. ~		1.10	•	
			31 Date filed (Marth Day Vacal	camer -	140	CFN	P						
	Sta Registra	te ar	31. Date filed Month, Day, Year, 1	32. Registrar's Si	lature 4	Med							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2010 Year **Physician** Mary C. Newcomer РМ 19 4:27 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/14/1915 **Funeral** Months Days Hours Min 1 □ M 2 🛛 F 94 185-28-4294 PA Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County show 7 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, it a Merice Examiner must be notified at Director 1 ☐Yes 2 X No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 Westfield Circle 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. 1 ∏Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: þ white 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ervin C. Hamme ပ Jennie P. Leib 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trau Jacqueline K. Peterson 20 Westfield Circle, Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Greenmount Cemetery 1/23/2010 York City, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Par 1. Enter the risease, complications that chases shock, or heart ailure. List only one can be on each in Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Difficule Intection Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, the attending physiclan hed for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mor Month Year 5 Other (specify) P.0. 9 ☐ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 → NO 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed has been 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate Vital 24 No 2 **4**0 1 🔲 Yes Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ ot Mary 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending 1 □Yes 2 □No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical fixaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29b. Signature and title of pertif 29d. Date sjigned (Monthy Day, Year) 29c. License number ٥ w completed cause 30. Name and addr 2 1 9 Thony erella

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician vewman IN January 26, 2010 10:17 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ATLANTIC GENERAL HOSPITAL WORCESTER BERLIN 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Year) Hours 1 M 2 X F 051-26-0211 77 New York Director 31 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Exprairs contest to recified at Directo 1 Yes 2 □ No Maryland Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 41 Drawbridge Rd. 21811 USA DOD: 1/26/10 12. Was Decedent Ever in U.S. Armed Forces?
1 □Yes 2 🏋 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Completed by If Yes, Give Specify. Specify: 3 Midowed 4 ☐ Divorced white Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) real estate agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maurice Schmuckler Anna Cohen 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19709 Boxberry Dr., Gaithersburg, MD 20879 19a. Informant's Name/Relationship (Type. Print) t of Health a Paul Newman son permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place Hillside Memorial 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) unknown Los Angeles, CA Park 21. Signature of Funeral Service Licenses Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1eas resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): 150-96-150 Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SSH ribrillation 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 ☐ Yes 2 ☑ No Jewman, Marilyn Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 ₹No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title ef_certifie 29c. License number 29d. Date signed (Month, Day, Year) 14.0 170663904 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 nhn (Sillosnie 314 Naklin Ave, Eife 302, 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2:05 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mandrin Chesapeake Hospice House Anne Arundel Harwood 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🞾 Months Days Hours Min. 02-20-192 Director Pennsylvania 578-18-2189 Usual Residence of Decedent shov 10a. State 10b. County at 10c. City. Town or Location 10d. Inside City Limits Director notified 28a-f MD Calvert 1 Tyes 2 X No Owings 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ed other than "natural", or items 23a o event, the Medical Examiner must be Funeral 10 Cross Point Drive 20736 Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 👿 No Specify: $^{\textit{Specify:}}$ white 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 11 homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evence. В. Florence Bavlor Arner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph D. Penn, grandson 6120 Alpine Court, Sunderland, MD 20689 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Veterans Cemetery 02-03-2010 | Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death
UCall Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): nding physician and use as the bunal-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown should be detached for Pregnant at time of death Unknown Day Year the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate Yes 2 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital nours after death.

neral Director: After this confilled in by the funeral dire 1 🗌 Yes 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Specify 27. Manner of Death

1 Natural
2 Accident
3 Suicide
4 Homicide 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

dew

State Registrar

DHMH 17 Rev 7/2009

O. Name and address of person who completed cause of death (Item 23a) (Type

32. Registra Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Of IVIA Registrar	_	epartment of F Ce <i>rtificate of L</i>			Reg. No. 2010	04106
	Physicia	n/	1. Decedent's Name <i>(First, Middle, Last)</i> Doris Elizabeth Parks		·		2. Date of Dea	Pay Year	3. Time of Death
	Medio Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death	0'	4c. County of Dea	1060471VI
and "			MINISULA SIGIDAAL MEDICAL 5. Social Security Number 6. Sex 7. Age	Centu	day) If Under 1 Year	SOUN If Under 24 Hrs.	Lo Data (Birt	NICOM	
	Funeral Director		215-12-6528 1 □ M 2 X F 8	(In yrs. last birtho	Months Days	Hours Min.	8. Date of Birtl (Month, Day 04-29-1	(Year) Co	thplace (State or Foreign ountry) yland
	and show Lat	or	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	Maryli 28a-f otifiec	Director	MD Wicomico	Tyaski	n				1 XYes 2 ☐ No
	ith the 3a or t be n		10e. Street and Number		10f. Zip Code			10g. Citizen of What C	ountry?
	eath w	Funeral	4303 Tyaskin Nanticoke Road 11. Marital Status 12. Was Decedent Ev		21865 13. Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-	USA 14. Race - Ame	erican Indian.
39	1 and 2 should be filed within 72 hours after death with the Manyland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates.	.о	If Yes, specify Cuba 1 ☐ Yes 2 📉 No		Rican, etc.)	Black, Whit	
2-0	hours "natur dical l	plete	15. Decedent's Education (Specify only highest grade completed)		Decedent's Usual Occup Give kind of work done o		ina	16b. Kind of Business	
21215-0036	ithin 72 ene. • than the Me	Completed	Elementary/Seconday (0-12) College (1-4 or 5+) Ìi	ife. DO NOT use retired)	umig most of work	mg	0 11	
ک 2	filed wi al Hygid d other event, t	Be	17. Father's Name (First, Middle, Last)	IH	<u>omemaker</u>	18. Mother's Nam	e (First, Middle, I	Own Home Maiden Surname)	
ylar	lid be f Menta larked atic e	욘	Richard Joseph Barry			Elizabe	th Fleet	wood	
Maryland	12 should alth and Me 27 is marl		19a. Informant's Name/Relationship (Type, Print) Diane W. Schevel/daughter		Mailing Address (Street a				
Baltimore,	o ° = 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of D	Disposition (Name of crematory or other place	e)	Date	20c. Location - City or	Town, State
E E	Pa in Fr	1 2	4 ☐ Donation 5 ☐ Other (Specify) 21. \ Ignature of Funeral Service \(\frac{1}{2} \)	Asbury	U.M. Cemet			Mt. Vernon	, Maryland
Ba	permit. Departr Importa any inji	(MINERA NEWNAUX MO	0295	22 Name and Address Hinman Fun	rset_Ave.	Princ	ess Anne,	MD 21853
			29 Part 1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line.	he death. Do not	t enter the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Inysician/ Medical	Ç (8	mediate Cause (Final sease or condition resulting in death)	consequence of	Primmert	11			Onset and Death
	Examiner	_	Sequentially list conditions, b.	Johnsoquerioe oi,	,				
	ted I	Examiner	if any, leading to immediate Due to (or as a decause. Littler Underlying Cause (Disease or linjury	consequence of)):			9	
	cate be executed physician and the burial-transit		that initiated events resulting in death) Last C. Due to (or as a c	consequence of)):				
760	ficate be of physicials the bur	edic	d						
30	death certifi ne attending ed for use a	an/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2		3 Ectopic pregnanc	v		23d. Date of de	livery
		ysici	in the past 12 months? 1 Yes 2 No 9 Unknown		5 Other (specify)	,	_	Month	Day Year
P.0	requires that the been signed by to should be detach	by Pł	Part II. Other significant conditions contributing to death but			en in Part I.		bacco use contribute to	-
rds,	equires een sig nould b	eted	ASCHD Congestin	e Alna	L. Farlu-e		1 🗆 Y		robably 4 LUnknown
ၓ	The law nate has both	Completed by Physician/Medical					24a. Was a autop perfor	sy prior to med? death?	topsy findings available completion of cause of
<u>8</u>	Physician: The law this certificate has al director, page 2 :	Be C	25. Was case referred to medical examiner?		26. Pla	ace of Death (Chec	1 🗆 Yes k only one)	2 No 1 ⊔ Ye	s 2 No
<u>=</u>	Physic this ce	은	I . □ Hospitai:		patient 3 DOA Othe	4 ☐ Nursing Ho		ence 6 Other (Spec	ify)
o uo	ending l sath. or; After he funer	Certificate:	1 Natural 5 Pending (Month, Ďay, 12 Accident Investigation		ury work	Yes 2 No	28d. Describe ho	ow injury occurred	
IVISI	I or Atta after de Directo	Certi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc.		n, street, factory, office	-	28f. Location (St City or Town	reet and Number or Ru n, State)	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certific completed filled in by the funeral director,	edical	29a. Certifier 1 Certifying Physician: To the best of m (Check 2 Medical Examiner: On the basis of examiner:	mination and/or i	investigation, in my opinio	n, death occurred a	the time, date an	d place, and due to the	cause(s) and manner stated.
	To the within To the compl	Σ	only one) 3 Certifying Nurse Practioner: To the be	TOL OILINY KNOWIEC	29c. License			cause(s) and manner as	h, Day, Year)
	XHI		(South Khans	>7	D5	5427		Junuary 1	9 2010
	4		30. Name and address of person who completed cause of dea	th (Item 23a) (Ty	pe, Print) 11/16/0 51	590	Sbury	mo	
ŀ	Stat Registra		31. Date filed (Month, Day, Year) 32. Aegistrar's	s Signature	pe, Print) 11/16/0 5/ Jacks				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ARKER AGGIE 0900 M 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Tate Hospice House Anne Arundel Linthicum Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 F Months Days Hours Min. February 100, Year 24 Marwland Director 219-34-2692 85 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1282 Graff Ct. Apt 1B 21401 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗶 No 0. 1X Never Married 2 ☐ Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: **Black** 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be flied within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Mex any injury or other traumatic event, the Mex gones. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6th Housekeeping Private Family Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Hosa Parker Maria Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Gaines(Granddaughter) 7900 Allard Ct. Apt 103 Glen Burnie, 20a. Method of Disposition 20b. Plade of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Memorial Gardens 1 - 20 - 104 ☐ Donation 5 ☐ Other (Specify) Annapolis, Md. M. Marne Roasson & Sons Mortuary, 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 1700483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Unset WHH Physician, disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events the burial-transi and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ signed by the atte in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed² After this certificate 2 🗌 No Yes 2 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 No 욘 4 Nursing Home 5 Residence 6 Other 6 HOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accider 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certification 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) EFENSE HIGHWAY ANNAPOLISMA2140, AEL

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month

2

aistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Port 11:35 PM leva **Physician** benvary 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 10/12/1936 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🔀 F 262-64-5775 73 Brazil Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Arnold Maryland Anne Arundel Director 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number death with items 23a or 1639 Bald Eagle Road 21012 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
unt: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: White Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baker Bakery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, Be Dulce Bottas Charles G. Hasler 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph C. Port Sr. - Husband 1639 Bald Eagle Rd, Arnold, MD 21012 other ! 20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort lincoln Crematory 1/25/2010 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State Brentwood, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home Nochit. Klobei 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pheumonia Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Just e mycloblastic **Examiner** levkemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician; The law requires that the death certificate be executed use as the burial-tran and resulting in death) Last Due to (or as a consequence of) iding physician Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. the þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I à Division of Vital Records. 1 Tes 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No 2 No certificate 24 hours after death.

Funeral Director: After this certificaletely filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide Hospital 29a. Certifie 1 Ccrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

To the I within 2

29b. Signature and title of certifier

-baya 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 22

completed cause of death (Item 23a) (Type, Print)

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month DULE 0930 Year / D Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2706 Gingerview Lane Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 09/16/193 9. Birthplace (State or Foreign Funeral 1 ÅM 2 ☐ F Hours Min Director 384-30-5480 76 . Michigan Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits ms 23a or 28a-f s must be notified 1 Yes 2 No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2706 Gingerview Lane 21401 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status ral", or iten Examiner 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) t of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Agent Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Chulay Michael Podoley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Maude Podoley/Spouse 2706 Gingerview Lane, Annapolis, MD 21401 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ō 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 01/28/2010 | Brentwood, Maryland Signature of Funer & Se 22. Name and Address of Facility Beall Funeral Home NW Crain Hwy. Bowie. MD 20715 23d Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Dun to for as a punsed were one Exami Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy been signed by the atter should be detached for u in the past 12 months?

1 Yes 2 No Month 4 Pregnant a 9 Unknown Pregnant at time of death Other (specify) Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy this certificate Yes 2 To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: 은 ER/Outpatient 3 DOA 4 Nursing Home 5 Desidence 6 Other (Specify) 1 Inpatient 2 I 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 \square Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State) within 24 hours a Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗍 re and title of certi Date signed (Month, Day, Year) 2010 no completed cause of death (Item 23a) (Type, Print) DEFENSE HIGHWAY ANNAPOLIS MDZIYO m AT 441

DHMH 17 Rev 7/2009

State

Registrar

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2010

31 Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year January 20 2010 Medical Martha Jane Peterson 0730 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mandrian Hospice House <u>Harwood</u> Arundel Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F Months Days Hours Min. (Month, Day, Year) Director 214-38-5552 1933 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 10d, Inside City Limits 1 X Yes 2 No M<u>arylan</u>d Anne Arundel Annapolis 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 1011 Jackson Street 21403 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married 2 (No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Black 3 Widowed 4 X Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) f other than " Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Domestic 9+h <u>Private Family</u> 27 is marked othe traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ James A. Wallace Martha Johns permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nora Colbert (Daughter) Jackson St. Annapolis, Md. 21403 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pk. Bestgate Mem. 1/26/10 Annapolis, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sons Mortuary Annapolis, M Reese & West St MOUY8 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) Metastatic Cancer Medical Due to (or as a consequence of) Examiner Due to (or as a consequence of) Carcinoma Sequentially list conditions Examiner if any, leading to immediate Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2X No Month Pregnant at time of death 5 Other (specify) Day Year 4 ☐ Pregnant 9 ☐ Unknown detached g Unknown as been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has h autopsy perform page 2 certificate Yes 2X 1 Yes 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 2**X** No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c, Injury at Certificate: 28d. Describe how injury occurred injury work? Natural 5 Pending 2 Accident
3 Suicide 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause certifying Nurse Pragitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated tractioners. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and 29d. Date signed (Month, Day, Year) pleted cause of death (Item 23a) (Type, Print) address of person Traze et 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

JAN 2

10-00992 David Platts

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

David Platts		S 1- For State Registrar	tate of Maryla		artment o		nd Ment	tal Hygiene	20 Reg. No.	0 0
Physici Medical Exami		1. Decedent's Name (First, Mide	die,Last) DAVID ST	TANLEY P	PLATTS			2. Date of D Month Februar		3. Time of Death 1037 hrs
		4a. Facility Name (if not instituti 3952 Peace Cliff Roa		mber)		4b. City, Town, o	or Location o		4c. County of	of Death
Funeral Director		5. Social Security Number 138-24-8050	6. Sex	7. Age (In yrs. I.			ear If Under ays Hours	Min	Birth(MM/DD/YYYY	9. Birthplace (State or Foreign NEW JERSEY
w any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Locat	tion				10d. Inside City Limits
: Maryland r 28a-f show	Director	10e. Street and Number	TALBOT			10f. Zip Code	TRAPP	<u> </u>	10g. Citizen of Wh	•
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho- injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Di	11. Marital Status	Married Armed Fo	edent Ever in U.		as Decedent of F es, specify Cuba	21673 Hispanic Origi an, Mexican,	in? (Specify Yes or Puerto Rican, etc.)	No- 14. Race White	USA - American Indian, Black,
ours after de atural", or xaminer m	à	3 Widowed 4 Dir	ivorced If Yes, Give Year or Dates: ecify only highest grade			nt's Usual Occup		sind of work done	Specify:	WHITE siness/Industry
215-0036 be filed within 72 ho ntal Hygiene. rked other than "n; ent, the Medical Es	Completed	Elementary/Secondary (0-12)	4		during m	ost of working lif	ETAKER			MANAGEMENT
21215-0 ould be filed Mental Hyg marked oth	To Be Co	17. Father's Name (First, Middle 19a. Informant's Name/Relations	LESLIE A. P.	LATTS	I 19b. Mailine	Address (Stre		LU	e, Maiden Surname) LA WILLIAN Jumber, City or Towr	MS
MD 3		MARION P.	SHARP / SISTE	ER	, , , , , , , , , , , , , , , , , , , ,				BRIDGETON,	
IOFe, ges land t of Heal : If iten		20a. Method of Disposition 1 Burial 2 Cremation	n 3 Removal fro	om State	crematory or oth			Date 2/4/2010		City or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If iter injury or other tr		4 Donation 5 Other S 21. Signature uneral Service		МІВ		EMATION CI lame and Addres			CAM	IBRIDGE, MD
m ឧភ្ម.ទ Physician	-	23a. Part I. Enter the disease, or	r complications that ca	aused the death.						CAMBRIDGE, MD 21613
/Medical Examiner		Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)		thermia	a and pr				"complicat	Between Onset and Death
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a c	consequence of	f):					
cecuted n and transit	I Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a c	consequence of	f):					
O, be ex	edical	UNPENDED	AMENDED 23	la,27,28	}a−f peı	r me G90	1 3/8	/10 TT		
Box 6876(e death certificate the attending phy ed for use as the b	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Uni	he 23c. If yes, or	nutcome of pregr nth ant at time of dea	nancy 2 Fet	tal death 3 her (Specify)		pregnancy	23d. Date of c Month	delivery Day Year
P.O. E res that the c signed by the be detached	2	Part II. Other significant condit	ions contributing to	death but not re	sulting in the u	nderlying cause	given in Part			oute to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O. Box the Hospital or Attending Physician: The law requires that the death hin 24 hours after death. the Funeral Director: After this certificate has been signed by the arreplayer filled in by the funeral director, page 2 should be detached for upon 10 to 1	Completed							perf	opsy pr formed? de	Vere autopsy findings available iror to completion of cause of eath? Yes 2 No
fital Residents The is certificate irector, page	å	25. Was case referred to medica examiner?	Hospital:	patient 2	ER/Outpatient		Othor	Check only one)	Decidence 6 d	Jan
ion of Vital I tending Physician: eath. or: After this certifi	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend 2 X Accident Invest	28a. Date or (Month, I	of Injury Day,Year)	28b Time of In	njury 28c. Inju	ury at Work?	wo subjec		d cardiac even
Division To the Hospital or Attention 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 Coul 4 Homicide			ome, farm, stree	et, factory, office I	building, etc.	28f. Location or Town, Trappe	(Street and Number State) 3952 T	y river edge ror Rural Route Number, City Peace Cliff Rd
To the How within 24 h			hysician: To the best miner:On the basis of and manner sta	f examination an						
F * F 8	¥	29b. Signature and title of certifie				29c. Licens O.C.			29d. Date signed February 4,	d (Month, Day, Year) 2010
	+	30. Name and address of person Ana Rubio MD. Ass		•		tract Politim	oro MD 3	21201		
	-11-	31. Date filed (Month, Day, Year)		strar's Signatur		treet, Baltimo	ore, MD 2	1201		
Regist	rar	FFR (5 2010 2	T. RATE AND	1. A. 19	Man				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of Ma	aryland / Dep	artment of F ertificate of L		Mental Hygi	ene		
		Registrar 1. Decedent's Name (First, Middle, I	Last)		runcate or L	Jeaui	2. Date of Death	g. No. 2	10	3. Time of Death
Physic Med		Nathaniel H	Pye				Jan. 22	_	Year	10:40 A M
Exam		4a. Facility Name (if not institution, g			4b. City, Town, or	Location of Death		4c. County of	of Death	
anger of the same		2617 Kenton Pl				Temple 1	Hills	Pri	nce (George's
Funera Directo	_	577-76-7787	. Sex 7. Age 1 ☑ M 2 ☐ F	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs, Hours Min.	8. Date of Birth (Month, Day, Feb. 12	Yea <i>r</i>)	9. Birthpi Count	lace (State or Foreign ry) DC
nd how	5	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10	Od. Inside City Limits
faryla 3a-f s iffied	Funeral Director	Maryland Prince	e George's	3.		Temple H	i11s		1.	1 X Yes 2 □ No
the A	₫	10e. Street and Number			10f. Zip Code			Og. Citizen of W	hat Count	try?
s 23a nust t	lera	2617 Kenton 1	Place			20748		United	l Sta	tes
baltimore, Maryland 21213-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Fur	1 Never Married 2 X Marrie	12. Was Decedent E Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates.		Was Decedent of H If Yes, specify Cuba 1 Yes 2 X No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- America , White, e Bla	tc.
hours lical I	Completed	15. Decedent's	s Education		dent's Usual Occup		- 1	6b. Kind of Bus	siness Ind	ustry
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Maryland 21213-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	10 B	17. Father's Name (First, Middle, Las Theodore Pye	st)				ne (First, Middle, Ma Dorothy	,	hita	
ould by mark mark	Ι.	19a. Informant's Name/Relationship	(Type Print)	401- 14-3			<u>·</u>			
Ma 12 shulth an 127 is 1 trau		Pamela Pye/ Wif			ing Address (Street a		emple Hil			
other		20a. Method of Disposition		20b. Place of Disp	osition (Name of		Date 2	Oc. Location - 0		
Page nent c int; If	П	1 A Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐ Removal from State		matory or other place Memorial	Jan	uary 30, 010	Landov	ær.	Maryland
baltimore, permit. Page 1 and Department of Heal Important: If item: any injury or other once.		21. Sig ature Funeral Service Lice		1 -11 -2	2. Name and Addres	s of Facility St	ewart Fu	neral He	ome,	Inc. 20019
		23a. Part 1. Inter the disease, or co shock, or heart failure. List only	omplications that caused	the death. Do not en	er the mode of dying	g, such as cardiac	or respiratory arres	t,		Approximate
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eath certificate at for use as f	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	f <u>pr</u> egnancy				23d. Date	of dolivor	
or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transition.	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown		☐ Ectopic pregnanc: ☐ Other (specify)	y 		Mont		y Day Year
s that	by F	Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying cause giv	en in Part I.	23e. Did toba	cco use contrib	ute to the	cause of death?
day	ted			·			1 🗆 Yes	2 🔀 No 3	Proba	ably 4 🗌 Unknown
The law requires cate has been signage 2 should be	Completed						24a. Was an autopsy performe	pri ed? de		sy findings available ipletion of cause of
VICAL PAR Tysician: The his certificate director, pag	B	25. Was case referred to medical examiner?	Hospital:			ice of Death (Chec	k only one)			
g Phys g Phys er this	12	1 Yes 2 No 27. Manner of Death	1 Inpatie	nt 2 ER/Outpatie		4 L.I Nursing Ho	ome 5 X Residen			
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rs after safter ed in			building, etc.	(Specify)			City or Town, S	State)		ŕ
To the Hospital or Attending Phys Within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Medical	(Check 2 L Medical Exa	nysician: To the best of n miner: On the basis of ex urse Practioner: To the b	amination and/or inves	tigation, in my opinio	 death occurred a: 	the time date and	place, and due to	o the caus	e(s) and manner stated
Vith Con E		29b. Signature and title of centifier	0		29c. License			d. Date signed (i		
		10/asta	12.100			666	Ja	nuary 2	7, 2	010
R10		30. Name and address of person who Dona Leskiski MI	9200 Basil	Court Su	Print)	Largo, Ma		20774		
Sta Regist		31. Date filed (Month, Day, Year) JAN 2 7 2010	Description 32. Register	's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Q6 Year Lawana Riggin 1106 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8. Date of Birth
(Month, Day, Year)
11-12-1947 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗹 F Months Days Hours Min. 219-48-8388 Director 62 D.C. Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important if frem 27 is marked other than "natural", or iteme 222 any injury or other traumatic 10a. State 10c. City Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 33495 Five Bridges Road 21853 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 KNo Specify: if Yes, Give Year or Dates Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) none Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Elwood Schuller Lucille Gill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendell B. Riggin/husband 33495 Five Bridges Road, Princess Anne, MD 21853 20a. Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 01-25-2010 Salisbury, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Hinman Funeral Home 11673 Somerset Ave., Princess Anne, MD 21853 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician/ acute chmis Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine If any leading to immedicause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last wholism Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 4 Pregnant at time of death g Unknown Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown Records. Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autons certificate 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ဂ္ 1 🔲 Yes 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA this ieral 1 Natural Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) within 24 hours a To the Funeral I completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Datersigned (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

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		State Registrar	Maryland / Depa <i>Cei</i>	rtificate of		Reg	. No.	0 0 7 1
Physici /Medic		1. Decedent's Name (First, Middle, Last) Edward Alan Rosenkrans				2. Date of Death 0 1 2 8 / 2 () Pay Yea	3. Time of Dea 0250 /
Examir		4a. Facility Name (If not institution, give street and number Harford Memorial Hospit		4b. City, Town, o	de Grace		4c. County of De Harlord	
Funeral Director		5. Social Security Number 6. Sex 7 1 № M 2 □ F	Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. E	Sirthplace (State or For Country)
W		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Li
r 28a-f show rotified at	tor	Maryland Harkond	Havre de					1 Yes 2
or 28g	Funeral Director	10e. Street and Number		10f. Zip Code		"	. Citizen of What	
s 23a	eral	1204 Bern Drive		21078	l' 0 - 1 - 0 / 0			tes of Amer
natural", or items 23a or 28a-f show	by	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Deceder Armed Force: 1 ☑ Yes, Give Year or Date:	No	Was Decedent of F If Yes, specify Cub 1 □Yes 2 12 No	dispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wh Specify: (1)	
"natural"	leted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup kind of work done	oation during most of workii d)	ng 16	b. Kind of Busines	ss/Industry
	ошо	Elementary/Secondary (0-12) College (1-4o	First	DO NOT use retire. GNEEL	d)	Pi	ublic Scr	wice
Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Item Monee.	To Be Completed	17. Father's Name (First, Middle, Last) Paul Rosenbuans			18. Mother's Name Maxine P	(First, Middle, Ma	iden Surname)	
is ma rauma		19a. Informant's Name/Relationship (Type. Print)			and Number or Rura			
Health em 27 ther t		Linda Rosentrans (wife) 20a. Method of Disposition			ie, Haure		c. Location - City of	
ent of it: If it y or o		1 Warial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, cren				•	
oortan Sortan Injur		4 Donation 5 Other (Specify) 21. Signature of Funeral Service (Sepsee)	Harford 11	CMONUCUL(2. Name and Addre	iss of Facility 70	-2010 Ab	eracen, 1 10xal Har	ie P.A. ?
and and and and and and and and and and		\$ (D)	12	3 S. Vas	ess of Facility Ze hington St	E. Haurc	de Grace	, MD
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2 33	Completed by					24a. Was an autopsy performe 1 ∐Yes 2 ∑	d? prior t	
certif	Be	25. Was case referred to medical examiner? Hospital: Hospital:		t 3 D DOA Oth	26. Place of Death			
eral di	۲	27. Manner of Death 28a. Date of Ir	atient 2 ER/Outpatier	N OLDON	4 🗆 Nursing Hor	me 5 Residence 28d. Describe how		pecify)
r death. ector: After this certifica by the funeral director, p	atio	1 ☑ Natural 5 ☐ Pending (Month, I 2 ☐ Accident investigation	Ďay, Year) Injury		k? Yes 2 □ No			
within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of I building,	njury - At home, farm, stre etc. <i>(Specify)</i>	eet, factory, office	2	28f. Location (Stree City or Town, S	et and Number or . State)	Rural Route Number
24 hou Fune stely fil	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the besise and manner	of examination and/or in	n occurred at the ti vestigation, in my o	me, date and place, opinion, death occurr	and due to the cau ed at the time, date	se(s) and manner and place, and d	as stated. ue to the cause(s)
thin the	Me	29b. Signature and title of certifier		29c. Licens		29d	. Date signed (Mo.	nth, Day, Year)
2 2 S		Dum 4	MD	100	68014		1128/10	5
.w 7 ⊗			f death (Item 23a) (Type,	1	,		-)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 01/20/2010 Year BERTHA LUCIA RAMIREZ 0745 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** 1 □ M 2 💢 F Months Days Hours Min. South America Director 07/23/1918 215-66-8739 death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 No Silver Spring Montgomery MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or traumatic event, Ir Medical Examiner must be r USA 20902 1135 University Blvd. West, #706 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1**∏**Yes 2□No 2 Specify: Specify: Hispanic 3 √Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) Ukn 18. Mother's Name (First, Middle, Maiden Surname) Ukn Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 Is any injury or other trau once. 422 N. Summit Avenue, #202, Gaithersburg, MD 20877 <u> William Ramirez - son</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/25/10 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Hanover, MD 22. Name and Address of Facility Snowden Funeral Home Signature of Funeral Service Acensee 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fin-1) Physician 6 months disease or condition resulting in death) Hypertensive nephropathy /Medical Due to (or as a consequence of): Examiner 5 years Cornary artery disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown The law requires that the death 3 Ectopic pregnancy Month Day Year 5 Cher (specify) 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by Diabetes 1 ☐ Yes 21 No 3 ☐ Probably 4 ☐ Unknown this certificate has been sral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 2 ZNo 1 Tyes ospital or Attending Physician: Thours after death.
Ineral Director: After this certificatly filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Division Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the Hosp within 24 hou To the Funel completely fil and manner stated. 29c, License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D52382 2010 person who completed cause of death (Item 23a) (Type, Print) 4701 Randolph Road, #216, Rockville, MD 20852

Registrar

DHMH 17 Rev 1/2001

State

Danilo Molieri
31. Date filed (Month. Day, Year)

JAN 25 2010

52. Registrar's Signature

		Ple	ease Type or Pri					•		0	
		For State	State of M	arylar		artment of F rtificate of		,	0	2010	01116
		Registrar 1. Decedent's Name (First, Mi	iddle, Last)		0.6		Dealli	2. Date of Dea	Reg. No ath		3. Time of Death
Physicia /Medic		Beulah A. Rus	sh					Februa	ry	2, 2010	8:45 P
Examin		4a. Facility Name (If not institu)			r Location of Death		4c.	County of Death	
Funeral		Goodwill Menno 5. Social Security Number		ae (In vrs.	last birthday)	Grantsv If Under 1 Year		8. Date of Birl		arrett 9. Birth	place (State or Foreign
Director		215-44-9181	1 □ M 2 🔀 F	, , , , , , , , ,	98 Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da April	23,		ntru)
and and		Usual Residence of Decedent 10a. State 10b. Cou		10c. Cit	ty, Town or Lo	ocation					10d. Inside City Limits
Maryl I-f sho	tor	MD Garr	rett	Acc	ident						1 X Yes 2 □ No
ges 1 and 2 should be filed within 72 hours after death with the Maryland in of Health and Mental Hygiene. The file file is 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Mydical Examinar must be notified at	Director	10e. Street and Number				10f. Zip Code				izen of What Cou	ntry?
eath w	Funeral		Dr., Apt. 17		6 12	21520	lianania Origina (Ca	anife Van av Na	US		an Indian
or item		11. Marital Status 1 ☐ Never Married 2 ☐ N	Armed Forces? Married 1 □ Yes 2 🔀	•		Was Decedent of H If Yes, specify Cuba		Rican, etc.)		14. Race - Ameri Black, White,	
ural", o	d by	3 X Widowed 4 ☐ Divord	ced If Yes, Give Year or Dates:			1 □Yes 2 x No	Specify:			Specify: Wh	nite
n 72 h	Completed	(Specify only hig	dent's Education ghest grade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	ing	16b. K	ind of Business/Ir	dustry
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be file tral Hy d othe event,	Be	17. Father's Name (First, Midd	•				18. Mother's Name			Surname)	
I y I d hould id Mer marke matic	၉	Luther B. Kel 19a. Informant's Name/Relation			105 Maili	ng Address (Street	Christin				- 0- 4-)
nd 2 s nd 2 s alth an 27 ls i		Rita Kremer/D				RC Lane,				1531 1531	o Code)
es 1 a of Hea		20a. Method of Disposition	on 3 Removal from State	20b. F	Place of Dispo cemetery, crei	osition (Name of matory or other place	ce)	Date	20c. Lo	ocation - City or To	own, State
t. Pages 1 tment of 1 tant: If ite		4 Donation 5 ☐ Other	r (Specify)		. Paul	's Luth.	Cem. Feb.	5, 201	O A	ccident,	MD
Default Dec. 10. permit. Pages 1 and 2 Department of Health a my Injury or other tra once.		21. Signature of Futheral Servi	rice Licensee			2. Name and Addre O. Box 2				l Homes, 21536	P.A.
		23a. Part 1. Enter the disease	, or a mplications that cause	d the deat						21336	Approximate Interval Between
[∖] ्Physicían		immediate Cause (Final disease or condition	List only one cause on each li	ne.	Acut	e Roxoi	mtory	Fail	140	>	Onset and Death
/Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of):	2	, O	1			
	-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseq	uence of):	neum	lonia				
cuted nd ransit	Examiner	Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C.								
		resulting in death) Last	Due to (or as	a conseq	uence of):						
eath certificate be attending physic	Physician/Medical		d								
th certification in the sending	J.W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			∃ Ectopic pregnanc				23d. Date of deliv	ery
The law requires that the death certificate are has been signed by the attending physoage 2 should be detached for use as the	sicis	in the past 12 months? 1 ☐ Yes 2 ANo 9 ☐ Unknown	4 ☐ Pregnant a			Other (specify)	· · · · · · · · · · · · · · · · · · ·			Month	Day Year
that the detacl		Part II. Other significant cond	ditions contributing to death b	ut not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco i	use contribute to t	he cause of death?
quires an sign uld be	ed by	Aleho	imer den	nen	tia.			1 🗆 Y	es 2	□ No 3□ Pro	bably 4X Unknown
e law requir has been s je 2 should	Completed	DM	type II		,			24a. Was autop		24b. Were auto	ppsy findings available impletion of cause of
	Com		J'					perfoi	med? 2 No	death?	2 □No
Physician: The this certificate ral director, pag	Be	25. Was case referred to medi examiner? 1 ☐ Yes 2 No	Hospital:		5010:	Othe	26. Place of Deat			_	
g Phy gerthis	<u>ان</u>	27. Manner of Death	28a. Date of Inju	ıry	28b. Time of Injury	IL 3 L DOA	4 Nursing Ho	me 5 Resid		6 ☐Other (Speci y occurred	fy)
tendin eath. or: Af	catio	E LI TOOIGOIK	estigation	ly, rear)	mjury		Yes 2 □ No				
or At after d Direct in by	Certification:		ermined 28e. Place of Inj building, et	ury - At ho c. <i>(Specif</i>	ome, farm, str	eet, factory, office		28f. Location (S City or Tow	treet an n, State	d Number or Run)	al Route Number,
		29a. Certifier 1 Certif	fying Physician: To the best	of my kno	wledge, deat	h occurred at the tir	me, date and place,	and due to the	cause(s) and manner as	stated.
the Ho nin 24 the Fu npletel	ledical	one)	cal Examiner: On the basis of and manner st	of examina ated.	ition and/or in			red at the time,	date and	d place, and due t	o the cause(s)
7	Σ	29b. Signature and title of certi	inter	inti) .	29c. License	4	7)	29d. Dat	te signed (Month,	Day, Year)
	2	30. Name and address of pers	son who completed cause of o	leath (Iten	n 23a) (Type		VO () C		4	2/10	
d	5	Muhammad Naee	em, M.D., 625	Kent	Ave.,	,	4, Cumber	land, M	D 2	21502	
Stat Registra		31. Date filed (Month, Day, Yea	4 2010 32. Begistr	ar's Signa	iture	- 14					
ricgistia		700	I COID	4	O. 18						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1/21/2010 **Physician** Theodore John Rokosz 9:04 Α /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex . Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 1 M 2 □ F 185-26-7700 Director 3/26/1936 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a, State 10b. County 1 ☐ Yes 247XNo MD Anne Arundel Riva Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be I death with 12 Cherry RD. 21140 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White etc. Pages 1 and 2 should be filed within 72 hours after 1 X Yes 2 ☐ If Yes, Give Year or Dates: 2 No 54-1 Never Married 2 Married altimore, Maryland 21215-0036 1 □ Yes 🏋 No White Specify: Completed by 3 ₩Widowed 4 Divorced 56 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) UNK Grocery Manager Giant Foods traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Rokosz Mary Murzyn ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 is any injury or other trauonce. Windber, Judy Tomasewski 643 Dark Shade DR. PA 15963 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State 1/26/2010 Holy Cross Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Conemaugh, PA 22. Name and Address of Facility Hardesty 21. Signature of Funeral Service Licensee Funeral Home, P.A. 180 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 5 e 1cemia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, physician the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 3 Probably Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has Yes the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only onle) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA Certification: To After this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Al<u>Natural</u> 2 Accident 5 Pending investigation Injury 1 ☐ Yes 24 hours after death. 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only within 2 one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ress of person who completed cause of death (Item 23a) (Type, Print) Q150M MD

DHMH 17 Rev 1/2001

State Registrar Registrar's Signature

State Registrar 30. Name and address of

270

31. Date filed (Month

DHMH 17 Rev 1/2001

erson who completed cause of death (Item 23a) (Type, Print)

FARM

12d.

32. Registrar's Signature

19/2010

Dr. William Dabbs

21017

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 2010 12:40 P M Robert Eugene Rohrer Jan /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington 13103 National Pike Clear Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/05/1931 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) Days 1XM 2 1 F 78 215-26-1596 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No Director MD Washington Clear Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21722 US 13103 National Pike Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify. 2 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Conductor/Brakeman Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Louise Baker William Henry Rohrer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14920 Clear Spring Rd., Williamsport, MD 21795 19a. Informant's Name/Relationship (Type. Print) Robert K. Rohrer / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 01/27/2010 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, MD 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licens e 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 3 hours disease or condition resulting in death) Struke Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE yes, outcome pf pregnancy □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) ☐Yes 2☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Obstructive Onlmonary Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No

P.O. Box 68760

certificate be executed burial-transit and ed by the attending physician detached for use as the buria Division or Vital Records, has After this certificate

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

CTo the Funeral Director; After this certifica completely filled in by the funeral director, t

Medical

29b. Signature and title of certifier

2 Accident

3 ☐ Suicide

4 Homicide

(Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

29d. Date signed (Month, Day, Year) 27/2010

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6+

Tu Bui Mo 1138 31. Date filed (Month, Day, Year) JAN 27

6 Could not be determined

32. Pegistrar's Signature

Hagerstown

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 10:40 A 2010 Edward Daniel January Rehbein, Jr. 30 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Chester River Hospital Chestertown der 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) New York If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Months Min 1 X M 2 □ F 426-47-8355 40 1969 22 Director May Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, The Modical Evaluation is used by a Milling at 1 ☐ Yes 2 No Director Marvland Caroline Ridgely 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number be filed within 72 hours after death with 11592 Holly Road 21660 United States of America Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Caucasian Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) <u>Salesman</u> Lumber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Daniel Rehbein, Sr. Dawn Louise Childress ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sment of Health an Edward D. Rehbein, Sr. Father 11592 Holly Road, Ridgely, Maryland 21660 other 1 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Denton Cemetery 2/3/2010 Denton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ours disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** arter Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed persension attending physician and for use as the burial-tran resulting in death) Last (or as a consequence of): O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 □Yes 2 □ No 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown ₫. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2 No 3 DOA 1 Inpatient 2 ER/Outpatient Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation the within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

DHMH 17 Rev 1/2001

State
Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Year Sandra Lynn Rossbach 0500 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death ediona If Under 1 If Under 24 9. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth **Funeral** 218-58-0922 1 □ M 2X□ F Months Davs Hours Min. (Month, Director Usual Residence of Decedent 10b. County Wicomico 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location Salisbury 10d. Inside City Limits Director 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 USA 715 Richwil Dr. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 X No Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ Insurance Insurance Agent Be 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Littleton 17. Father's Name (First, Middle, Last) ഉ Wilson Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 715 Richwil Dr., Salisbury, MD 21804 Kenneth Rossbach / husband injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔲 Burial 2 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Crematory of Delmarva 1/24/10 Delmar, DE 22. Name and Address of Facility Bounds Funeral Home 705 E. Main St., Salisbury, any inj once. nature of Funeral Service Licensee inis 23a. Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BREAST Physician/ METASTAGIL disease or condition Medical resulting in death) **Examiner** Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death Unknown Month Yes 2 No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has Director: After this certificate 25. Was case referred to medica æ 26. Place of Death (Check only one) examiner? Certificate: To 1 🗌 Yes 2 No Other: Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 2 🗌 No Investigation 6 Could not be Accident filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after To the Funeral Direc Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one ature and title of certifier 29b. Sig AFAR SADIO 1-23-2010

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year

100

E. CAMOII ST.

21801

d address of person who completed cause of death (Item 23a) (Type, Print)

M.D

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2

			For State Registrar	State of Marylar	-	tificate of L		, ,	Jiene Reg. No. 🤈 🎧 📗 (01.122
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	7		-		2. Date of Dea Month	th Day Year	3. Time of Death
	Medic	al	Randolph G. Red 4a. Facility Name (if not institution, give str					01	17 2010	06:13 AM
	Examin	er	PONINGULA SEGIONAL	/	40/		Location of Death	1	4c. County of Dea	ith •
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	16/ last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9, Bi	rthplace (State or Foreign
	Director		217-44-1917 1K	^{M 2 □ F} 62	Yrs.	Months Days	Hours Min.	(Month, Day) 4 - 29 - 1	Year) Co	ountry)
	and show lat	or	10a. State 10b. County	10c. Cit	ty, Town or Loc	cation				10d. Inside City Limits
	Maryla 28a-f	Director	MD Wicomic	o sal	lisbur	۸.				1 ☐ Yes 2X No
	h the laor? beno		10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
	th wit ms 23 must	Funeral	1729 Emerson Ave			21801			U.S.A.	
(0	or iter	by Fu	11. Maritai Status 1 Never Married 2 Married	 Was Decedent Ever in U. Armed Forces? XYes 2 □ No A1 	lf.	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puert	ecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
8	rs afte iral",		3 ☐ Widowed 4 【X*Divorced	If Yes, Give Year or Dates 1967		☐ Yes 2X No	Specify:		Specify: Bl.	ack
21215-0036	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Deced	ent's Usual Occupa	ation during most of wor	kina	16b. Kind of Business	Industry
7	ithin 7 ene. • than	Com	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DC	NOT use retired)	Ü		State of	Dolorrom
2	filed w al Hygi d other	Be	1.7. Father's Name (First, Middle, Last)		рттес	tor of		ne (First, Middle, N	State of Maiden Surname)	ретамате
Maryland	d be fi Jenta Irked Itic ev	입	Randolph G. Reed	i. Sr				ne Gor	,	
ar)	2 should be th and Men 27 is marke traumatic	- 33	19a. Informant's Name/Relationship (Type		19b. Mailin				City or Town, State, Zi	p Code)
ري ح			Mary Taylor/Sist					Salisbu:	ry, MD218	301
Baltimore,	. 0		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Ref			sition (Name of atory or other Ga		1	20c. Location - City or	
를	permit. Page Department Important: I any injury or	-2	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Spr		ill Mem	11 6		Hebron, M	
B	Dep Imp any		Market	0/5	Fe Fu	nnie Sm neral H	inth 91	7 W. Is Lisbury	abella St	11
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the deat	h. Do not ente	r the mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
and .	Physician/	6.7	Immediate Cause (Final disease or condition	The State of the Comment of the second	EROTI	CARD	INVASO	ULAR	DISEASE	Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):					
		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence ot):					
	executed an and rial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.							
	e exec cian al nurial-t	al E	resulting in death) Last	Due to (or as a consequ	uence of):					
8/60	eath certificate be executed attending physician and for use as the burial-transit	Medical	d.							
õ	certifi inding use as	Ž	IF FEMALE: 23b. Was decedent pregnant 23c	c. If yes, outcome of pregna					23d. Date of de	livery
Box	death of the atter	Physician/N	in the past 12 months? 1 Yes 2 No	1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown		Other (specify)	у		Month	Day Year
Э. С.	at the did by the stacker	Phy	9 Unknown Part II. Other significant conditions contr		ulkin – i – Ma			Т		
ν. J.	res tha signed	d by	Part II. Other significant conditions contr	buting to death but not res	aiting in the un	idenying cause giv	en in Part I.		pacco use contribute to	o the cause of death? robably 4 Unknown
ğ	requii been should	letec						24a. Was ar		topsy findings available
Kecords,	e has	Completed						autops perforr	prior to	completion of cause of
<u> </u>	an: TI rtificat rtor, pa		25. Was case referred to medical			26. Pla	ace of Death (Chec	1 Yes 2	2 ≦ No 1 ⊔ Yes	2 14 No
VIta	hysici his ce I direc	၉	T L tes 2 LINO	spital:	ER/Outpatient	3 DOA Othe	r: 4 Nursing H	ome 5 - Reside	nce 6 Other (Spec	ify)
ם ר	ling P I. After tl funera	ate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work?	?	28d. Describe ho	w injury occurred	
<u> </u>	Vttend death ctor: / y the 1	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho	me farm stree		Yes 2 □ No	20f Leasting /Ct	mot and Number or Du	m I Davida Niverbay
DIVISION	al or A s after Il Dire		4 ☐ Homicide determined	building, etc. (Specify		st, lactory, office		City or Town	reet and Number or Ru , State)	rai noute Number,
	To the Hospital or Attending Physician: The law requires that the der within 24 hours after death. To the Funeral Director After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached.	edical	29a. Certifier 1 Certifying Physicia (Check 2 Medical Examiner	an: To the best of my knowl On the basis of examination	edge, death or	ocured at the time,	date and place, a	nd due to the caus	se(s) and manner as sta	ated.
	the L thin 24 the F mplet	Σ	only one) 3 L. Certifying Nurse P	ractioner: To the best of my	/ knowledge, de	eath occurred at the	time, date and pla	ce, and due to the	cause(s) and manner as	stated.
_	\$\$\$ ₹ ¥		29b. Signature and title of certifier	217	And	29c. License	Cocco	2:	9d. Date algned (Month	1, Day, Year)
,	1	ŀ	30. Name and address of person who com	pleted cause of death (Item	23a) (Type. Pri	int)	00515		1/11/10	
	Dr		MTHIMMANAY	AMA 614	BEA		WILE I)R	SALIS	BLAY M	1) 2/804.
	Stat Registra	-	31. Date filed (Month, Day, Year) JAN 25 2010	32 Registrar's Signat	ure					
	registra		Vnii & 0 /U/()	worms 1	7. 13/2	No.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day GREGORY MICHAEL SKINNER 10:04 AM Jan. 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Upper Chesapeake Medical Center Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min 216-48-3136 Director 62 Iowa Usual Residence of Decedent 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits it of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, if a Medical Experient must be notified at 1 ☐ Yes 2 No MD. Harford White Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Island 2450 21161 Funeral Branch Road United States 12. Was Decedent Ever in U.S.
Armed Forces?
1 X Yes 2 □ No
If Yes, Give
Year or Dates: Vietnam 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No 2 Specify: 3 Widowed 4 Divorced Specify. White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner Engraving 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should by Health and Men Louis Alfred Skinner ဥ Elizabeth Anne Hilton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Important: If item 27 any injury or other tra Diana Skinner (Wife) 2450 Island Branch Rd. White Hall 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 3, 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) White Rose Crematorium 2010 **York,** Pennsylvania 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral Home, P.A. Jarrettsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Muccardial disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Coronary aftery if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 1 ☐ Yes 2 ☐ No 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown page 2 should Completed Obesity 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy certificate perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State

within 2 To the I

(Check only one)

29b. Signature and titl

of certif

ermin Barrueto M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

annay

Gregory

29c. License number

Do057223

. 500 Upper Chesapeak . Dr. Bel Air, MO

29d. Date signed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04/24 State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Catherine Swann February 2010 11:58 AMM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick College View Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
June 7m 1907 7. Age (In vrs. last birthday) Funeral 9. Birthplace (State or Foreign 1 M 2 TyF 218-30-7675 102 Yrs. Mary Tand Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2X No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1718 Shookstown Road 21702 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc þ 1XXNever Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) House Keeper Private Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file, and Mental F Harriet Virginia Frazier John Benjamin Swann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2211 Banner Hill Road, Frederick, MD 21702 Kenneth O. Cooke, nephew 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. John's Cemetery Feb. 5, 2010 Frederick, MD 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 2Keenevadii Basford PA Funeral Home M00255 106 Fast Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Stooke robable disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and and tran Due to (or as a consequence of) resulting in death) Last physician a sthe burial-Physician/Medical Box 68760 nding p IF FEMALE 23c. If yes, outcome of pregnancy
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1 Yes 2 No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) February 4, 2010 > 60417 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas sha h TOMOSIN State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 02 Physician/ ∩5 Day Bernard Schreiber 2010 0450 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany WMHS Frostburg NRSG & Rehab Center Frostburg If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 🗆 F Months Hours Min. Director 215-38-7692 Maryland Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Allegany LaVale 1 🗌 Yes 2 🗶 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Winchester Road S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Yes Yes, Give 2 No 1956-Maryland 21215-0036 1 Yes 2 No Specify Specify: 3 Widowed 4 Divorced Completed Year or Dates 1961 White 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 t. Department of Health and Mental Hygiene. Important: If feen 27 is marked other than "na any injury or other traumatic event at any once. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Post Office Carrier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph F. Schreiber Clara Regina Condry Schreiber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Minnick 20a. Method of Disposition Old Line Ave. Laurel MD sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Cumberland Crematory 02-06-2010 Cumberland, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Sowers Funeral Home, P.A. 60 W Main Frostburg 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Recurrent month Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death 2 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cerebral 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 Yes 2 No ☐ Accident Investigation 6 Could not be filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined ledical 29a. Certifier Scertifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO055325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) p Walsh Rd Cumberland MD 21502 SHIN 925 32. Registrar's State Registrar

DHMH 17 Rev 7/2009

JOHN BYYON SORrell Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 2010 04126 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Month **Medical Examiner** 1449 hrs John Byron Sorrell January 24, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 866 Bayview Drive Edgewater Anne Arundel 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Country) Director Months Days Hours 217-44-9037 1 X M 2/15/1946 2 F 63 DC Washington, Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show must be notified at once. 1 Yes 2 X No Anne Arundel Maryland | Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once-Edgewater Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 866 Bayview Drive 21037 USA Funeral 11. Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Vac 3 X Widowed White 4 Divorced If Yes, Give Year Yes 2 y No specify: ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ years Attorney Law 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Wilfred Byron Sorrell Viola Elizabeth Bullock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan E. Sorrell/ Sister 307 Bay View Drive, Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State St. James' Cemetery 2/2/10 Lothian, Maryland 4 Donation 5 Other Specify 22. Name and Address of Facility George P. Kalas Funeral Home 21. Sign ature of Funer 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Smoke inhalation and thermal injuries Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last tending physician and use as the burial - transit Physician/Medical X UNPENDED AMENDED 23a, PII, 27, 28a-f, permE, g900 2/18/10 TT IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death Ectopic pregnancy Dav Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 2 should be detached for Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Chronic alcohol abuse, alcohol intoxication ted of Vital Records, has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? page ✓ Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene this ER/Outpatient 3 DOA 1 V Yes 2 No 28a. Date of Injury (Month, Day,Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred ___ Natural n 24 hours after death.

e Funeral Director: A letely filled in by the fur Division subject in house fire 5 Pending 1 Yes 2 X No 2:49 pm 2 X Accident Fd28f. Location (Street and Number or Rural Route Number, City or Town, State) 866 Bayview Dr 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be or Town, State) Edgewater 866 MB determined (Specify) Residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal To the I 2 📝 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 25, 2010 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Pate filed (Month, Day, Year)
FEB 1 7 2010 32. Registra 's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 01/30/2010 Carmela Gioeni Scala 6:30р м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Asbury Solomons Solomons Calvert 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Italy **Funeral** 8. Date of Birth 1 M 2 X F Days Hours Min. 06/21 / Director 079-18-7533 88 °1921 Usual Residence of Decedent al Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MDCalvert Solomons 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20688 11100 Asbury Circle 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: White Specify 3XXWidowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last)
Salvatore Gioeni permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname)
Maria Alibrandi t. Page 1 and 2 should be treent of Health and Men rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print)
James Scala/Son 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) 1621 Colonial Oak Court, Huntingtown, <u> 20639</u> Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ft. Lincoln Cem 20c. Location - City or Town, State Date 1 🖪 Burial 2 🗌 Cremation 3 🗆 Removal from State 02/04/2010Brentwood, MD 4 Donation 5 Other (Specify) 21. Sign vur of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert 8125 Southern Md Blvd., Owings, MD20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician a.CEREBRO VASCULAR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner FARI THERSSLLFROTIC CARDIOVASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence on After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ M 1 Yes 2 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 24 hours after death Funeral Director. 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

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32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 2010 Sally Bruce Mann Supplee 6:10 Α 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 1 □ M 2 🔯 F Months Days Hours Min. <u>216-24-3335</u> 87 01-10-1923 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Anne Arundel Deale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5916 A, Deale Churchton Road 20751 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 📉 No Black, White, etc. 1 ☐Yes 2 XX If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 □ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Nursing, Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Armistead Mann Amv Rinker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally S. French, daughter 14 Sunnyview Court, Germantown, MD 20876 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖫 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2/2/2010 | Alexandria, VA of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheroscienotic Cordio Vosculas ons ease disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 MINo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Fibritation 1 ■Yes 2 No 3 Probably 4 Unknown Chronic Obstructive Airway disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 □Yes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner The law requires that the death certificate be executed burial-transit and

Physician

/Medical

Examiner

10a. State

MD

Director

by Funeral

Completed

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it is INvalical Evaruitment must be notified at

permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tra

Baltimore, Maryland 21215-0036

attending physician for use as the buria signed by the a cate has been si To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified funeral director,

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical 2 Completed Be Certification: To filled in by the

Medical

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident

5 Pending investigation 3 Suicide 6 ☐ Could not be

4 Homicide determined 28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number D. 50653 urana

32. Registra s Signature

29d. Date signed (Month, Day, Year) 2-1-2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5851 Deale church 31. Date filed (Month, Day, Year)

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State Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ \mathbf{P}_M ANNIE LUCILE SCHWEITZER JANUARY 2010 4:38 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death HOSPICE OF QUEEN ANNE'S HOSPICE CENTER CENTREVILLE OUEEN ANNE'S Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🗶 F Months Hours Min. JUNE II 85 Director 432-30-1986 ARKANSAS Usual Residence of Decedent show 10a. State 10b. County 10c, City, Town or Location notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 X No MARYLAND QUEEN ANNE'S QUEENSTOWN 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral 23a 100 RUTLEDGE ROAD UNITED STATES 21658 items hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 No ö þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates. **1950–1953** "natural", Specify: WHITE 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "n.
any injury or other traumatic event, the Next 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 **CLERK** COMMUNICATIONS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ COLUMBUS D. COLLINS CARRIE ELIZABETH HARPER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN CHARLES SCHWEITZER/HUSBAND 100 RUTLEDGE ROAD, QUEENSTOWN, MARYLAND 21658 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, CROWNSVILLE VETERANS CEMETERY 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CROWNSVILLE, MARYLAND 21. Signature de la Service Licensee FELLOWS, HELFENBEIN AND NEWNAM FUNERAL 106 SHAMROCK ROAD, CHESTER, MARYLAND 21 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final 2HE MERS DISEASE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury Due to (or as a consequence of): -transit Exam death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-t Physician/Medical Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months' Day Pregnant at time of death 5 Other (specify) the a 9 Unknown g Unknown P.O. n signed by tl d be detache requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 2 No No 1 Yes Physician: 25. Was case referred to medical examiner? funeral director, æ 26. Place of Death (Check only one) HOSPICE Hospital: 2 1 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Director: After this of in by the funeral director CENTER 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending injury work? 1 \(\text{Yes} \quad 2 \(\text{\box} \) No Natural 5 Pending death. ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Funeral I 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurs ractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signat of certifie 29d. Date signed (Month, Day, Year) 28

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31. Date filed (Month, Day,

Registrar

Stevers 16

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

614

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar MEND#7perFH, 1/25/10, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Cory James Simmons 12:22 2010 January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner National Naval Medical Center Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ★ M 2 □ F Months Director 10/21/1981 462-91-7180 Texas Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show ir than "natural", or items 23a or 28a-f show 1 1 Yes 2 □ No Director <u>Alexandria</u> VA Alexandria 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2000 Huntington Ave. Apt. 909 Funeral 22303 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status a filed within 72 hours after dal Hygiene.

other than "natural", or iten Black, White, etc. 1 ⊠Yes 2 □ No Navy If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 🛣 No Specify. ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kInd of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Naval Intellegence Armed Forces of Health and Mental Hygi Item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cheryl Ann Reed Mark Ray Simmons 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Ray Simmons / father 5312 LaVaca Ave., Midland, TX 79707 Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Memorial 01/20/2010 Midland, TX 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility} Danzansky-Goldberg Memorial Chapels,Inc 21. Signature of Funeral Service Licensee Kurt Blake M01477 1170 Rockville Pike Rockville, MD 20852 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) BURKITT'S LYMPHOMA **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a d be detached f 9 I Inknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ cate has been signated by page 2 should b 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 XNo 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 XNo 2 ER/Outpatient 3 DOA 1 X Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 28d. Describe how injury occurred

law requires that the death certificate be executed P.O. Box 68760 Records, Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p.

with the Marylan

death

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be nent of Health and Mental

1 Natural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) and manner stated 29b. Signature and title of certifier

29c. License number RES-000

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 01/22/2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stacy Chronister LT MC USN

National Naval Medical Center

20889~ Bethesda, MD 5600

State Registrar

Medical

29a. Certifier

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010° 11:40pm Dong WOO Shin January 21 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Montgomery Rockville Casey House 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🕅 M 2 🗆 F Months Days Hours Min. 1 1775/1926 Director 216-37-2386 83 Korea Usual Residence of Decedent shov 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location Director ems 23a or 28a-f sh r must be notified a Silver Spring 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20905 U.S.A. 517 Grand Cupress Court or items "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married 1 ☐ Yes 2 🕱 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 - Widowed 4 - Divorced Completed Asian Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Distributing Entrepreneur Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Kisum Shin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 517 Grand Cypress Court, Silver Spring, MD 20905 Daniel Shin - Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Norbeck Memorial Park 01/25/2010 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, at only one cause on each line. 23a. Part 1. Enter the di shock, or heart fail Approximate Immediate Cause (Final Onset and Death Physician Aspiration Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of Examiner <u>Advanced</u> Dementia cuartially list our citions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Year Day Yes 2 No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) P Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) Hospice 1 Tyes 2 🗓 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural n 24 hours after death.

e Funeral Director: After the function of the functin 5 Pending 1 🗌 Yes 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier соппретед 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) January 22, 2010 MD 60634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, Maryland 20855 M.D.Joseph, 31. Date filed (Month, Day, Year) JAN 25 2010 Registrar's Sie State

Registrar

DHMH 17 Rev 7/2009

Registrar

nded item 03/2010; (#] cs	. per physician Pleas	se Type or Prin State of Ma	it in Bl	ack Indel	ible Ink.	Ensure Al	I Copies	Are L	egible.	
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Physici	an	1. Decedent's Name (First, Middle,	Last)	dt	FMMA	SCHMIT	т	2. Date of De Month	eath Day	Year 1 O	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution,	give street and number)				Location of Death			ounty of Death	4
Funeral		5. Social Security Number	6. Sex 7. Age	(In yrs. las		Jnder 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	9. Birth	place (State or Foreign
Director		217-22-1826	1□M 2\F 86		Yrs. Mo	nths Days	Hours Min.	(Month, Da 03/20	/1923	MD	ntry)
ryland		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Locatio	n				1	10d. Inside City Limits
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inimportant: If time 77 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event. The Madical Examiner must be notified a once.	Director	MD Garre	ett	Mtn	. Lake 1	Park of, Zip Code			t0a Citiza	en of What Cour	Y Yes 2 No
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ner wi	Funeral	11. Marital Status	12. Was Decedent E Armed Forces? 1 ☐ Yes 2X N		13. Was I	Decedent of Hi , specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	0- 14	Race - Americ Black, White,	
ral', or	þ	1 Never Married 2 Married 3 Widowed 4 XDivorced	If Yes, Give Year or Dates:	10	101	es 🛣 No	Specify:		S	pecify: Whi	te
"natu edical	Completed	15. Decedent (Specify only highest	grade completed)		16a. Decedent's (Give kind life. DO N	Usual Occupa of work done of OT use retired	ition luring most of work)	ing	16b. Kind	of Business/In	dustry
The A	Comp	Elementary/Secondary (0-12)	College (1-4or 5	+)	Nurse				Не	alth	
eveni	Be	17. Father's Name (First, Middle, L	ast)				18. Mother's Name		, Maiden Si	umame)	
umati	P	Delphas Callis 19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailing Ad	dress (Street a	INCLLIE I		er, City or T	Town, State, Zip	o Code)
em 27 i ther tra		Michel Beck, So 20a. Method of Disposition	on	20h Pla	P.O. Be		, Mtn. La	ake Par		21550 ation - City or To	own State
ry or o		1 ☑Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		cen	netery, cremator land Cei	y or other plac	9)			and, MD	
importa any inju		21. Signature of Funeral Service L	icensee	Care	22. Na	me and Addres	s of Facility				
		23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that caused	the death.			Burdock cond St., g. such as cardiac			2155	Approximate
ysician		Immediate Cause (Final disease or condition	only one cause or each lin	10. _U.W	i non	a					Onset and Death
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rial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	a conseque	ence of):						
the bur	Ical		d								
for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23	d. Date of deliv	ery
should be detached for use	sicial	in the past 12 months? 1 ☐ Yes 2 Ø No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			pic pregnancy er (specify)				Month	Day Year
e detacl	by Phy	Part II. Other significant condition	ns contributing to death bu	ut not result	ing in the underl	ying cause give	en in Part I.	23e. Did	tobacco use	e contribute to t	he cause of death?
d bluot	ted b	Demen	tia					1 🗆	Yes 2	No 3 □ Prol	bably 4 Unknown
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rector, page 2	Be Co	25. Was case referred to medical examiner?					26. Place of Deat		one)	1 🗆 Yes	2 □ No
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or: Atter	Certification;	1 Natural 5 Pending 2 Accident investig	(Month, Day ation	(Year)	Injury	28c. Injun Work	k? Yes 2□No				
in by t	artific	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ot be ned 28e. Place of Inju- building, etc	ry - At hom c. (Specify)	ne, farm, street, f	actory, office			(Street and own, State)	Number or Run	al Route Number,
To the Funaral Director: After this certificate his completely filled in by the funeral director, page	calCo	29a. Certifier 1 Certifying	Physician: To the best of taminer: On the basis of	of my knowl	ledge, death occ	urred at the tim	ne, date and place.	and due to the	cause(s) a	nd manner as s	stated.
To the Funaral Director: completely filled in by the	Medical	one) 29b. Signature and title of certifier	and manner sta	ited.	anaor myesii	29c. License		red at the time		signe Month,	
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	1		who completed cause of de	eath (Item 2	23a) (Type, Print	491.	2-14	A	Dr	- Oal	11/11/1
Sta		31. Date filed (Month, Day, Year)	32. Degistra	ar's Signatu	re d		3011 1	Mos		UW	100
Registi	rar .	FEB-2	2010	المر مه	1. 1900						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day P^{M} Smith 2010 2:50 January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert 9713 Wildfire Lane Owings If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year 6-10-1942 Days Min. Hours 1 ★ M 2 🗆 F Mary land Director 579-54-8068 Yrs. 67 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 □ No Maryland Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral S. A. 9511 Sheridan Street 20706 items Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0. by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural". 3 X Widowed 4 Divorced Completed Year or Dates. the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 9 Elementary/Seconday (0-12) College (1-4 or 5+) Editors Press Pressman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Verna Bright Francis Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9713 Wildfire Lane, Owings, Maryland 20736 Joanne Santiago/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Resurrection Cemetery 1/26/2010 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service 22. Name and Address of Facility Robert E. Evans Funeral Home, 16000 Annapolis Road, Bowie, Maryland 20715 10 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Congestive Heart Failure Physician/ resulting in death) Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, cause (Disease or iinjury Generalized Arteriosclerosis Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No ed by the a 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Mellitus 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown certificate has been si irector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 X No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Daughter's Other: 4 Nursing Home 5 Residence 6 Other (Spec 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at work? Certificate: 1 X Natural 5 \square Pending 1 🗆 Yes 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Quitifying Nurse Freetlaner To the best of the knowledge. Seeth annur at the time, date and place, and due to the 29b. Signature and title o certi 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Α.

DAN 25

Raymon

31. Date filed (Month,

32. Registrar's Signature

Noble, MD, 238 Merrimac Court, Prince Frederick, Maryland

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Examine	r	4a. Facility Name (if			umber)			4b. City, Town		of Death		1	County o		
Funeral		3113 At1 5. Social Security N		ve . Sex	7. Age	(In yrs. la	st birthday)	Ocean If Under 1 Yes	r If Unde	r 24 Hrs.	8. Date of Birt	h	rcest	9 Birthr	place (State or Foreign
Director		276-28-10		1 🔀 M 2 □ F	77		Yrs.	Months Day	s Hours	Min.	0911571	·93/2		Coun	oH OH
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f Healt f Healt item 2 other	-	20a. Method of Dis	position			20b. P	lace of Dispos	sition (Name of	- 1		Date		ocation - C		
Page nent o int: If			☐ Cremation 3 5 ☐ Other (Sp		m State			Nat. Ce	i	3/10	0/2010	Arl	ingto	on, \	VΑ
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1	21. Signature of Fu	meral Service Lic	ensee \checkmark		1		. Name and Add	lress of Faci	lity	Burbage	Fur	eral	Home	
\$0 E # 9	_	MAIN	C 111	2000	POC	1					Berlin		2181	11	
		23a. Part 1. Enter the shock, or head immediate Cause	art failure. List on	y one cause on	each line.								0		Approximate Interval Between Onset and Death
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Completed by Physician/Medical	IF FEMALE:	-												
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requires that the despension by the should be detached	Ž	Part II. Other signi	ficant condition	s contributing to	death bu	t not resi	ulting in the u	nderlying cause	given in Par	t I.	23e. Did to	obacco	use contrib	ute to th	e cause of death?
quires en sigi			"LL MON								1 🗹	Yes 2	□ No 3	B 🗆 Prob	oably 4 🗆 Unknown
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eath. or: Aft the fur	Certificate:	1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending Investiga 6 ☐ Could no	tion		reary	injury		ork? Yes 2	□No					
or Att	Ser	4 Homicide	determin	ad 28e. Plac	ce of Injur Iding, etc.			et, factory, offic	е		28f. Location (S City or Tow			or Rural	Route Number,
spital		29a. Certifier 1	1 Certifying F	hysician: To the	best of m	ny knowl	edge, death o	ccured at the ti	ne, date and	d place, ar	nd due to the car	use(s) a	nd manner	as state	d.
in 24 h	Medical	(Check 2	2 ☐ Medical Ex 3 ☐ Certifying N	aminer: On the b	asis of exa	amination	n and/or invest	igation, in my op	inion, death o	occurred a	t the time, date a	nd plac	e, and due t	to the cau	use(s) and manner stated.
To t with To tl		29b. Signature and	title of certifier	loca #					nse number	-		29d. Da	ate signed	,	Day, Year)
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Registra	r		JAN26	ZUIU /	Lund		1. 100	ake							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item 17 State of Maryland / Department of Health and Mental Hygiene Registrar WCHD/SH 1/29/2010 per FH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 1-23-2010 William 3:16p M **Physician** Mickey Suder, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner National Pike Clear Spring Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3 – 1 4 – 1 9 3 3 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 € M 2 🗆 F Months Days Hours Min. Country) 220-30-9766 76 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Medical Examinar must be natified at Washington Clear Spring 1 ☐Yes 21/2 No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 12504 21722 National Pike Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 1 No 1 9 5 3 If Yes, Give Year or Dates: 1 9 5 5 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married Married Specify: white 1 □Yes &□No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) building contractor College (1-4or 5+) Elementary/Secondary (0-12) 12th grade stone mason 17. Father's Name (First, Middle, Last) Emory A. Suder, 18. Mother's Name (First, Middle, Maiden Surname) Be Emory A. Sunder. Goldie Pearl Graham ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 12504 National Pike Clear Spring, MD 21722 Betty J. Suder spouse Item 27 other to 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. Date 29 Department of Important: If It eny Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hagerstown, MD Cedar Lawn Cemetery 2010 4 Donation 5 Other (Specify) 21. Signature of Frankal Service Licensee 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc 23a. Part 1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Between onset and Death Immediate Cause (Final **Physician** Acute Myelogenous Leukemio 24ears disease or condition resulting in deeth) /Medical Due to (or as a prosequence) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of, Hospital or Attending Physicien: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ gastrointestinal bleeding 2 → Yo 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Atherosclerotic Heart is certificate h director, page 1 ☐Yes 2 ☐ M6 Be 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Pruneral Director: A 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

05H-10+1

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

JAN 28 2010

synthe Kuttree-Sands, no

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cynthia Kuther-Sands, MD Hospice of Washing ton County

31. Date filed (Month, Day, Year)

D47451

erstown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yee Jesse Lester Shoemaker Jr. 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 12402 Indian Springs Road Clear Spring Washington 8. Date of Birth (Month, Day, Year) 10-22-1939 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **№** M 2□ F Days Hours 220-40-2311 70 Yrs. MD Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MID Washington Clear Spring 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12402 Indian Springs Road 21722 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2√☐ No Specify: 3 ☐ Widowed 4 M Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) brick mfg.co Elementary/Secondary (0-12) College (1-4or 5+) truck driver 10th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Jesse Lester Shoemaker Sr. Dorothy J. Mummert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Steven L. Shoemaker 11526 French Lane Hagerstown, MD 21740 son 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 1, 20a. Method of Disposition 20c. Location - City or Town, State Ty Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Big Pool, MD Parkhead Cem. 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc 234. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory affest, shock, or heart ailure. List only one cause on each line. MD 21722 ate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due or as a consequence of: Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 🗌 Yes 2 XNO 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 esidence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Physician /Medical Examiner requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

10a. State

Director

Funeral

þ

Completed

Funeral

Director

Item 27 is marked other then "natural", or Itams 23s or 28s-f show other traumatic event. If a Madical Exact must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural", or Itan Importent: or other traumatic event, Itan Medical Ever in ar 9008.

Saltimore, Maryland 21215-0036

with the Maryland

death

Examiner use as the burial-transit attending physician þ ed by the a detached f page 2 should be director, after death.

Physician/Medical þ Completed Be ٩ Certification;

Medical

29a. Certifier

OBH-10

To the Hospitel or Attending Physicien:

24 hours a

within 2 To the

State Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

29b. Signaturà and title of certifie

W 32. Registrar's Signature 2010

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month William Charles Smith, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hospice at the sud eild Vicemico 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** 9 - 1 - 1 9 2 9 1 XM 2 □ F Month Hours Director 80 220-26-2178 Usual Residence of Decedent 28a-f shov 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Pocomoke City MD Worcester 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2408 By Pass Road 21851 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinone. 1 Yes 2 No If Yes, Give Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specificack 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Smith Emma Jordan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosa Smith/Wife 2408 By Pass Road, Pocomoke City, MD 21851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sinai Bapt Ch:1/30/2010|Wardtown, MD 22. Name and Address of Facility Bennie Smith 917 W. Isabella St. Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset a a eath shock, or heart failure. List only one course on each line. Immediate Gause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 1 Yes 2 Unknown ate has been signed by the page 2 should be detached significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ē Completed 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe • Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate by Yes 2 No 1 \square Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier D 29505 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR. SALISBURY, MD 21801

DHMH 17 Rev 7/2009

Registrar

10-00861 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Kelly Patricia Slaski State of Maryland / Department of Health and Mental Hygiene									
Telly Fatricia Olask	1- For State Center Cen	ertificate of Death		Reg. No. 2010 0414					
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last) Kelly Patricia Slaski		2. Date of De Month January	Day Year 30, 2010 3. Time of Death 0937 hrs					
	4a. Facility Name (if not institution, give street and number) Loch Raven Drive west of Bridge One	4b. City, Town, or Towson	Location of Death	4c. County of Death Baltimore County					
Funeral		s. last birthday) If Under 1 Yea	If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign						
Director	218-08-7279 1 M 2 K F 2	26 Yrs. World's Day	04/0	04/1983 Country Maryland					
w any	10a. State 10b. County 10c. Ci	ity, Town or Location		10d. Inside City Limits 1 Yes 2 No					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	MD Baltimore No. 10e. Street and Number	ottingham 10f. Zip Code	···	10g. Citizen of What Country?					
th the N 23a or 2 notified	13 Melken Court	21236		U.S.A.					
death with ritems 23 tust be no	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No	If Yes, specify Cubar	spanic Origin? (Specify Yes or N n, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.					
rs after or miner or by F	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	1 Yes 2 X No		Specify: White					
6 172 hour an "nate cal Exar		during most of working life		Baltimore County					
5-0036 led within 72 ho Hygiene. to ther than "na the Medical Ex Complete	12 4 17. Father's Name (First, Middle, Last)	Teacher	18.Mother's Name (First, Middle	Board of Education , Maiden Surname)					
21215 buld be file Mental H marked of c event, til	John Joseph Gibbons, Jr. 19a. Informant's Name/Relationship (Type, Print)	10h Mailing Address (Ove	Barbara Heler	Wittich umber, City or Town, State, Zip Code)					
MD 2 nd 2 shoul lith and M nn 27 is m summatic	Mark W. Slaski (husband)	, , , , , , , , , , , , , , , , , , , ,	urt - Nottingha						
imore, MD 2 Pages I and 2 shou ment of Health and N tant: If item 27 is n or other traumatic	20a. Method of Disposition 20t 1 X Burial 2 Cremation 3 Removal from State	 b. Place of Disposition (Name of ce crematory or other place) 	metery, Date	20c. Location - City or Town, State					
Baltimore, permit. Pages I at Department of Hee Important: If ite injury or other tr	24 Signature of Funcial Continuation	Parkwood Cemeter 22. Name and Addres	y 02/06/201	0 Baltimore, Maryland Sahn Funeral Home, P.A.					
	M01020 Heather Lassahn Chojnacki (per 23a. Part I. Enter the disease, or complications that caused the dea failure. List only one cause on each line. Multiple	DVR) 11750 Bela	ir Road - Kings	sville, Maryland 21087					
Physician /Medical	failure. List only one cause on each line. Multiple Immediate Cause (Final disease a. burroion) a	drug intoxication and alcohol use	on (citalopram,	lamotrigine, Between Onset and Death					
Examiner	or condition resulting in death) Due to (or as a consequence								
iner	if any, leading to immediate cause. Enter Underlying Cause	e of);							
scuted and transit transit	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence	e of):							
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Box 68760, e death certificate be the attending physic ed for use as the burthy system of the attending physic ed for use as the burthy sician/Med	1 Yes 2 No 9 V Unknown 9 Unknown	death 5 Other (Specify)							
P.O. Box 68760, start the death certificate be exgreed by the attending physician eletached for use as the burial by Physician/Medic	Part II. Other significant conditions contributing to death but no	t resulting in the underlying cause	,	tobacco use contribute to the cause of death? es 2 ✓ No 3 Probably 4 Unknown					
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that the stafter death. The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by P.				ppsy prior to completion of cause of death? 2 No 1 Yes 2 No					
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ision Attend or death. rector: by the r	Natural 5 Pending 2 Accident Investigation 2 Re Place of Injury - At	Fd 9:30 am	Yes 2X No unk puilding, etc. 28f. Location	(Street and Number or Rural Route Number, City State) LOCH RAVEN Dr. West					
Division o spital or Attending hours after death. neral Director: After filled in by the fune Certification:	4 Homicide	ark		State) Loch Raven Dr. West One, Towson, MD					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transMedical Certification: To Be Completed by Physician/Medical E.	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowle and manner stated.								
A	29b Signature and title of certifier	29c, Licens		29d Date signed (Month, Day, Year)					
	30. Name and address of person who completed cause of death (Ite	O.C.	WI. C.	January 31, 2010					
	Margarita Korell MD. Assistant Medical Exam	niner 111 Penn Street, B	altimore, MD 21201						
State Registrar	31. Date filed (Month, Day, Year) Separate Signature Si	8. parl							

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	Physicia	an	1. Decedent's Name Curti		. ,		г	Tayl	or					Mo	e of Deal		201	Year	3. Time of Death	4
ATT.	/Medic Examin		4a. Facility Name (I		igene			layı	OL	4b. Cit	y, Town, o	r Location		Jan	uary			of Death	1:00 A A	
and h	Examili		16750 Ma	ryland			,			Sw	anton						arre			
	Funeral Director		5. Social Security N 213–22–3	954	6. Sex	1 2□ F	7. Age (1 83		st birthday Yrs.) If Und Month	er 1 Year s Days	If Unde Hours	er 24 Hrs. Min.	(Mc	e of Birth onth, Day,	(Year)	6	Coun	lace (State or Foreig try) Virginia	дn
	land ow		Usual Residence of 10a. State	Decedent 10b. County			10	0c. City,	Town or L	ocation								10	0d. Inside City Limit	s
	e Mary 3a-f sh	Director	MD.	Garre	ett			Swa	nton										1 □ Yes 🍇 🗖 🖎	0
	th with th 23a or 24 ust be no	ral Dire	10e. Street and Nun 16750 M		eiH E	hway					Zip C <i>o</i> de 21561					_		State	-	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Everting must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed			Was Dece Armed For 1 ⊠Yes If Yes, Giv Year or Da	rces? 2 □ No ve	erin U.S WW.	. 13. 2		edent of Hoecify Cuba 2/12/100	lispanic C an, Mexic Specif	Origin? (Sp an, Puerto fy:	ecify Ye Rican,	s or No- etc.)			e - Americ ck, White, e v: Wh		
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and	d be filed ental Hyg ced other c event,	Be	17. Father's Name (Last)	, , , ,							velma Thelm	e (First,	Middle, I Fichr	Maiden nell	Surnam	ne)		
, Maryland 21215-0036	ind 2 should alth and Miles 127 is marles traumati	To	19a. Informant's Na Wanda Ta	ame/Relations	nip <i>(Type:</i>	Print)			19b. Mail 1675	ing Addre 0 Mai	ss (Street rylan	and Num	ber or Run ghway	al Route	Number Wanto	r, City o	r Town, Mar	State, Zip yland	Code) 1 21561	
altimore,	Pages 1 a ment of He tant: If item iury or othe		20a. Method of Disp 1 X Burial 2 Donation	☐ Cremation		noval from S	State	20b. Pla ce Gar	ace of Disp metery, cre rett	osition (Nematory or Mem .	ame of other place Gard	ens	01/ 201	31/ 0				City or To Mar	_{wn, State} yland	
Balt	permit. Depart Import any in		21. Signature of Fu	neral Service	Licensee	150	al				and Addre		DC		Fune				24.5.60	
			23a. Part 1. Enter the shock, or hea	he disease, or	complica	tions that ca	aused the	e death.					West				aryı	and	21562 Approximate Interval Between	
	Physician /Medical Examiner		Immediate Cause (disease or conditional resulting in death)	Final	a.	Non		MA	ace									T	Onset and Death	<u>r</u>
68760,	ate be executed nysician and he burial-transit	ical Examiner	Sequentially list cor cause. Enter Under Cause (Disease or that initiated events resulting in death) L		b. = c d		or as a co													
P.O. Box 68	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rat director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	230	. If yes, outo 1 ☐ Live b 4 ☐ Pregr 9 ☐ Unkno	oirth 2 É nant at tin	Fetal	death 3	□ Ectopic □ Other (pregnanc	у			lar de la constitución de la con			te of delive	ery Day Year	
rds, F	quires that n signed t uld be det	d by P	Part II. Other signif	icant condition					ting in the u	underlying	cause giv	en in Pari	t I.	23		bacc <i>o</i> u es 2[ne cause of death? ably 4 Unknow	/n
Division of Vital Records,	The law reate has bee	Completed by	- NO	MONI	A										a. Was a autops perfori			prior to cor death?	psy findings available inpletion of cause of	le
Vita	ician: certific ector,	å	25. Was case referrexaminer?		Hos	pital:					Oth-	or:	ce of Deatl	h (Chec	k only on	e)				
ð	g Phys er this eral dir	n: T	1 Yes 2 27. Manner of Death	h		28a. Date o	of Injury		R/Outpatie 28b. Time (28c. Injur	y at	Nursing Ho		Reside				y)	
ion	Attending r death. sctor: After by the funer	atio	1 Natural 2 ☐ Accident	5 Pending	ation	(Mont	th, Day, Yo	ear)	Injury	М	Worl 1 □	k? Yes 2[□No							
Divis	al or Att s after de il Directe ed in by t	Certification: To	3	6		28e. Place buildir	of Injury ng, etc. (- At hon (Specify)	ne, farm, st	reet, facto	ory, office			28f. Loc Cit	cation (Si y or Towl	treet an n, State	d Numb	er or Rura	l Route Number,	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Medical (29a. Certifier (Check only one)	1 Certifyin 2 Medical			asis of ex	caminati												
_	To th Vithir	Me	29b. Signature and	title of certifier							9c. Licens			44 4					Day, Year)	
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	Registra	ar	1.5	0 - 17	טוט.	CA.	سهديا	p.	190											

State of Maryland / Department of Health and Mental Hygiene 2010 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January Day 1 2010 Grace J. Truesdale 3:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 100 Tennessee Avenue Pasadena Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 25 9. Birthplace (State or Foreign Funeral Days 1 🗆 M 2 💢 F Hours Min. Maryland 213-26-4456 Director 96 913 Usual Residence of Decedent Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "marked" any injury or other than "marked". 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Pasadena 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 100 Tennessee Avenue 21122 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. by 1 Never Married 2 Married Yes 2 No 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Black 3 🗓 Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th 0 State of Maryland Nutrionist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Richard Miller Ellen Jacob 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph L. Truesdale Sr(Son) 100 Tennessee Avenue Pasadena, Md. 21122 20b. Oacerof Disperioby (Name of the 20a, Method of Disposition 20c. Location - City or Town, State Date X Burial 2 ☐ Cremation 3 ☐ Removal from State Fields Church 1-25-10 Millersville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 2W Manne al Reason F & lilty Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death U.L. a.r. shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) ar Medical Due to (or as a consequence Examiner Sequentially list conditions if any, leading to immediate cause. Enter Uniterlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregr 23d. Date of delivery Ectopic pregnancy in the past 12 mor Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown 2 No signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Ukknown Completed plnous peen Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy 1 Yes 2 No Yes 2 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred L atural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29c. License numbe Name and address of person who completed cause of death (Item 23a) (Type, Print) State 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. C. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 11:10 P Inomas **Physician** Elmer january 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 □XM 2 □ F 218-72-1453 49 Sept.30,1960 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show shirt if item 27 is marked other than "natural", or items 20a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Director Maryland| Talbot Easton 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 21601 U.S.A. Funeral 8590 Corsica Court Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 22 If Yes, Give Year or Dates 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: þ Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Material Handler 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alice Mae Thomas Elmer Herman Jacobs ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debora Thomas/spouse 8590 Corsica Court, Easton, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 X Burial 2 Cremation 3 Removal from State Feb.6,2010 4 Donation 5 Other (Specify) Sandtown Cemetery Hillsboro, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Fleegle and Helfenbein Funeral Home, PA 106 W. Sunset Ave., Greensboro, Maryland 21639 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition nupertension **Physician** Dulmonary /Medical resulting in death) Due to (or as a consa uence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed g physician and as the burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy Month Year in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 No Yes 9 Unknown ueen signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed' 2 No 2 🗌 No 1 Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 2 No 3 🗆 D**O**A 1 Yes 2 ER/Outpatient ၉ this Injury at Work? 28a. Date of injury 28b. Time of 28c 28d. Describe how injury occurred 27. Manner of Death Certification: I Director: After to in by the funer (Month, Day Year) 1 Natural Injury 5 Pending investigation 1 Yes 2 🗌 No 2 Accident after death 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) within 2 To the I the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

Rober

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

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January

600 North Wolfe St, Baltimore, MD, 21287

VALENZA, ANGELO

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			For State Registrar		•	rtificate of Death		eg. No. 2010	04144
	Physici	an	1. Decedent's Name (First, Middle,	Last)			Date of Dea Month	th Day Year	3. Time of Death
	/Medic		Angelo D. Valen:					26, 2010	6:35 a ^M
	Examin	er	4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or Location of Dea	th	4c. County of Dea	th
****			5. Social Security Number	ursing Center	(In yrs. last birthday)	Prince Frederick	8. Date of Birth	Calvert	thplace (State or Foreign
	Funeral Director			1 M 2 □ F	Yrs.	Months Days Hours Min	. (Month, Day	(Year) Co	ountry)
	W.		579-03-0741 Usual Residence of Decedent		91		April 24,	1918	NY
	yland now		10a. State 10b. County		10c. City, Town or Lo	cation			10d. Inside City Limits
	Mar 3-f st	Director	MD Calve	+	Saint Leo	nard			1 ☐ Yes 2. No
	r 28	ire	10e. Street and Number	1	Samueo	10f. Zip Code	1	10g. Citizen of What Co	ountry?
	within 72 hours after death with the Maryland glene. I than "natural", or items 23a or 28a-f show The Midical Evaminar must be notified at		2530 Carrity Poa	d		20685		USA	
	deat	Funeral	2530 Garrity Roa 11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puel	Specify Yes or No-	14. Race - Ame Black, Whit	
9	or ite		1 ☐ Never Married 2 Marrie)	1 □Yes 2 ☑No Specify:	no moan, etc./	Specify:	e, etc.
8	iral",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		TETO EENTO OPOSINI.		Specify.	White
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21215-0036	within iene. than "	E G	Elementary/Secondary (0-12)	College (1-4or 5+) life.	DO NOT use retired)			
N.	e filed w other t other t		ATT TO A SECOND	4		Businessmar	me (First, Middle,	Hardware Maidan Surnama	
an D	be fill	Be	17. Father's Name (First, Middle, La	ast)		18. Mothers Na	ime (<i>Firs</i> i, <i>Middle</i> , i	walderi Surrianie)	
ž	2 should be a and Mental is marked o aumatic eve	은	Domenic Valenz				Chimente		7. 0 . 1
14	12sh hand 7isn traun		19a. Informant's Name/Relationshi	(Type. Print)		ng Address (Street and Number or F			Zip Code)
o)	s 1 and 2 should be filed f Health and Mental Hyg tem 27 is marked othe other traumatic event,		Kathryn 20a. Method of Disposition	Wood - daught	er 141 20b. Place of Dispo	Walnut Cove Drive,	Lusby, MD	20657 20c. Location - City or	Town State
Baltimore,	ges it of l		1 ☐ Burial 2 🗃 Cremation 3	Removal from State	cemetery, crei	natory or other place)	Date	200. Location - City of	Town, State
┋	t. Pa tmer tant: ijury		4 ☐ Donation 5 ☐ Other (Spe		Lee Crem	atorium Janu	ary 27, 2010	Clinton, MD	
g B	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Li	D	22	2. Name and Address of Facility	Sewell Funera	al Home, P.A.	
	452 6 6					1451 Dares Beach Rd			678 Approximate
и			shock, or heart failure. List o	nly one cause on each line),	er the mode of dying, such as cardia			Interval Between Onset and Death
4	hysician		Immediate Cause (Final disease or condition resulting in death)	-a. COMPLIE	ATIONS O	FMULTITAFIRET	- DEM	FNTA	YEARS
A.	/Medical Examiner		resulting in dodding					-	YEARS
		<u></u>	Sequentially list conditions,		consequence of):	CARDIOVAJEVLAR	DISFATE		11 Paci
	ted nsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence or,			,	
	sath certificate be executed attending physician and for use as the burial-transit	xar	that initiated events resulting in death) Last	c Due to (or as a	consequence of):				
9	be e siciar buris	_	1						
387	death certificate e attending phys d for use as the l	Physician/Medica		d					
Box (certi nding ise a	/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o				23d. Date of de	livery
m	atte atte	ciar	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at		Ctopic pregnancy Other (specify)		Month	Day Year
o	the d y the ched	ıysi	1 □Yes 2 □ No 9 □ Unknown	9 🗆 Unknown					
σ.	law requires that the de as been signed by the a 2 should be detached t		Part II. Other significant condition	s contributing to death but	not resulting in the u	nderlying cause given in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
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<u>a</u>	iician: The l certificate ha rector, page						1 □Yes	2 ☐1Ño 1 ☐ Ye	s 2 🗆 No
Vital Records,	Attending Physician: sr death. ector: After this certific by the funeral director,	Be	25. Was case referred to medical examiner?	Hospital:		lau /	eath (Check only or		
ot	Phys this ral dii	은	1 ☐ Yes 2 ☐ ¶ No 27. Manner of Death	i 1 ☐ Inpatier	t 2 ER/Outpatie	11 3 LI DOA 4 LE Nursing		ence 6 Other (Speow injury occurred	ecify)
L	ding F h. After funera	io	1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day,	Year) Injury	f 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	200. Describe fi	ow injury occurred	
<u>S</u>	ttend death stor: / the	icat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be 280 Place of Injur	ry - At home, farm, str		28f Location /9	Street and Number or F	Jural Boute Number
Division	or A after Direc in by	Certification: To	4 ☐ Homicide determin	ed building, etc.	(Specify)	oos idolog, office	City or Tow		and Houte Humber,
_	spital ours ieral filled		29a. Certifier 1 Certifying	Physician: To the best of	mv knowledge, deat	h occurred at the time, date and pla	ce, and due to the	cause(s) and manner a	as stated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical E	xaminer: On the basis of and manner stat	examination and/or in	vestigation, in my opinion, death occ	curred at the time,	date and place, and du	e to the cause(s)
	o the	Me	29b. Signature and tifle of certifier		·	29c. License number	-	29d. Date signed (Mon	th, Day, Year)
	- > - 0) (PILI	Wand .		026 358		JANBART	26 2010
	2		30. Name and address of person w	ho completed could of the	ath (Item 23a) /Tunn				
JR	10+1		J8 H~	4. WEIVE		Print) -PRINCE FA	FJERIC !	t mil-	20678
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra			<u> </u>	, , , ,	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Alice Josephine Vitello 20ĬÖ January 8:10 p^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 232 North Blvd. Salisbury Wicomico If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. Hours 1 M 2 XF 186-28-0965 Director 10 31 1915 Pennsylvania Usual Residence of Decedent 28a-f show 10a. State traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Maryland Wicomico Salisbury 1 🛚 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 232 North Blvd. 21801 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. Specify: white Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) housewife domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alice Berona Pifer Glenn Franklin Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 232 North Blvd., Salisbury, MD 21801. Jodi Conway daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Lakelawn Memorial
Gardens 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) 1 28 2010 Reynoldsville, PA Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) oulmone Medical Du to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Be Completed by Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 IF FEMALE: IF FEMALE. 23b. Was decedent pregnant 23b. Was aget 12 mounts? 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month 1 Yes 2 No Month Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? pertension 24a. Was an autopsy performed Yes 21 2 🗌 No 1 Yes 26. Place of Death (Check only one) examiner?
1 Yes Other: Certificate: To 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one ure and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print) ElledA Ziemer egistrar's Signatu

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 9:50 AM Mary Madeline Wagner 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Baltimore Washington Medical Center Anne Arunde If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign Month, Day, Year) **Funeral** 1 🗆 M 2 🗓 F Maryland 213-10-8899 Director Dec. Usual Residence of Decedent 10b. County 10d. Inside City Limits f Heath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Funeral Director MD Anne Arundel Severna Park 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 315 Fernwood Drive 21146 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc þ 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) agner snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis P. Wagner / Husband 315 Fernwood Drive Severna Park, MD 21146 Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ō cemetery, crematory or other place) XBurial 2 Cremation 3 Removal from State Cedar Hill Cemetery Brooklyn, MD 2010 4 Donation 5 Other (Specify) 21. Signature of Exneral Service License 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) Du t (or as a consequence of) Examiner Sequentially list conditions, Examine b (or as a consequence of) day, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death ed by the a detached f 1 Yes 2 Unknown 9 Unknown been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 V Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas performed 1 Yes 2 No certificate within 24 hours after death.

To the Funeral Director; After this certifica completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) of Vital Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural (Month, Day, Year) 5 Pending Division Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) and title of certific 29d. Date signed (Month, Dav. Year) 29b. Signature 32 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31, Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registr<u>ar</u>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 0 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DRIEN Timonium Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar. 7, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days 216-03-97 1 □ M 2 □ F Mar. MD Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Modical Examinar must be redified 2t MD Baltimore 1 □Yes 2 X No Director Manchester 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21106 Weaver Road 21102 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 □Yes 2 No White ≥ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry H. Warner Mary L. Snyder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen L. Bull/Daughter 21106 Weaver Rd., Manchester, MD 21102 injury or other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or c Betnienem Steltz 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 2010 4 ☐ Donation 5 ☐ Other (Specify) Cemetery Glen Rock, PA 21. Signature of Funeral Service Licer 22. Name and Address of Facility J.J. Hartenstein Mortuary, 24 Second Street, New Freedom, PA 17349 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** anlus disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) certificate has been signed by the a rector, page 2 should be detached t 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Upknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2□No 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Other! 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Duath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registra State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene 23aPtI,25 per me 901,03/26/2010dhb
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 24 2010 CHARLES HENRY WILLARD \mathbf{P}^{M} 7:35 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death QUEEN ANNE'S 333 WILLARD POINT ROAD STEVENSVILLE Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Davs Hours Min. MARCH Day 8° 1924 MARYTAND Director 213-12-7759 85 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director 28a-f 1 Yes 2 No QUEEN ANNE'S MARYLAND STEVENSVILLE 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 333 WILLARD POINT ROAD UNITED STATES 21666 items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 6 Completed by 1 Never Married 2 X Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 Specify: WHITE 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Year or Dates. WWII the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 CHAIRMAN OF THE BOARD FOOD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ WILLIAM BURKE WILLARD LILLIAN ROWENA ENGELBRECHT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 333 WILLARD POINT ROAD, STEVENSVILLE, MARYLAND 21666 MELVIN WILLARD/SON Department of Healt Important: If item 2 any injury or other 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery crematory of other place)
CREMATION CENTER 1 Burial 2 X Cremation 3 Removal from State JANUÄRY 26 4 Donation 5 Other (Specify) 2010 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line nterval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical to for as a consequence of Examiner (Terminal) Sequentially list conditions, HED BY MEDICAL EXAMINER if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician CERT Physician/Medical 68760 as the L IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Day Month Year 4 ☐ Pregnant 9 ☐ Unknown the detached 9 Unknown Ö ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ته þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24a. Was an Were autopsy findings available prior to completion of cause of has I autopsy within 24 hours after death.

To the Funeral Director: After this certificate Formpleted filled in by the funeral director, page performe death? 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 □ 29b. Signature and title of certifier 10+1 MS ace

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Physic /Med		Adolph Joseph	Waitekunas				y 25 20	010 Year	3:40 P M				
Exami		4a. Facility Name (If not institution, give s 15528 Iron Rail S			Mt. Sav	_		Alle	nty of Death egany				
Funera Director		5. Social Security Number 214–16–2103 6. Sex Usual Residence of Decedent	7. Age (In yrs. las 89	ot birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th ay, Year) 19 1920	Coui	place (State or Foreign ntry) rland			
1215-0036 within 72 hours after death with the Maryland fiene. than "natural", or items 23a or 28a-f show he Modical Expriment than collined at	Funeral Director	10a. State 10b. County MD. Allegany 10e. Street and Number		Town or Loc				10g. Citizen o		10d. Inside City Limits 10d. Inside City Limits 10d. Inside City Limits 10d. Inside City Limits			
th with 23a or	ral Di	15528 Iron Rail S	t.		2154			Unite					
and 21215-0036 be filed within 72 hours after death with the Marylan tall Hygiene. bd other than "natural", or items 23a or 28a-f show event, the Modicel Examire mant be notified at	by Fune	11. Marital Status 1 ▼ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 No WW 2 If Yes, Give Year or Dates:	:	Vas Decedent of Yes, specify Cub ☐Yes 2X No		Specify Yes or No rto Rican, etc.)	Sper	Race - Americal Americal Research Resea				
21215-0036 d within 72 hours aft giene. er than "natural", or the Modicel Exami, in the Modicel Exami	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give I life, E	ent's Usual Occu kind of work done OO NOT use retire il Merch	during most of word)	orking	Ì	Kind of Business/Industry Ariety Store				
e filed al Hyg other	To Be Co	17. Father's Name (First, Middle, Last) Adolph Waitekunas 18. Mother's Name (First, Middle, Maiden Surname) Alice Martesauskis											
≥ p±2.‡		19a. Informant's Name/Relationship (Ty) Harry Price/ nephe	Rural Route Numb	, West	Virgi	nia 25177							
Baltimore, permit. Pages 1 ar Department of Hea mportant: If Item 3 my Injury or other my Injury or other		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State 20b. Pla	ce of Dispos netery, crem Peter	sition (Name of natory or other pla S Cemete	ery 01/ 201	729/ 0	20c. Location Wester	-	own, State Maryland			
Balt permit. Depart Import any Inj		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 111 Church St, Westernport, Maryland 21562											
Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. he cause on each line. Arterioscl	Do not ente	er the mode of dy	ing, such as card				Approximate Interval Between Onset and Death			
. Box 68760, death certificate be executed e attending physician and id for use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a conseque Due to (or as a conseque Due to (or as a conseque Due to (or as a conseque	ence of):									
O 0 E 0	ysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of de	death 3	Ectopic pregnar Other (specify)			23d.	Date of deliv	very Day Year			
rds, P.O quires that the n signed by that	d by Phys	Part II. Other significant conditions con	ntributing to death but not result	ing in the ur	nderlying cause g	ven in Part t.		tobacco use c		the cause of death? bably 4			
II Records, P.C. The law requires that the cate has been signed by the page 2 should be detach	Completed by						24a. Was auto perfi 1 🗆 Yes		b. Were aut prior to c death? 1 ☐ Yes	opsy findings available ompletion of cause of 2 □ No			
of Vital F Physiclan: Th rthis certificate rral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	lospital: 1 ☐ Inpatient 2 ☐ E	D/Outpatien	* 3 🗆 DOA O1	har-	eath <i>(Check only</i> Home 3/2 /Res		Other (Spec	if(t)			
Vision of Attending Physis redeath. ector: After this by the funeral di	ation: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury	28c. Inju		1	how injury occ					
· · · · · · ·	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)				City or To	iwn, State)		ral Route Number,			
Divi To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical		sician: To the best of my know ner: On the basis of examinati and manner stated.					e, date and pla	ce, and due	to the cause(s)			
To the within To the company	N N	29b. Signature and title of certifier	'An			nse number 19157		Jan. 2					
	+ VA	30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, 1 W 3r	Print) d St, Ci	mberland	a, MD 21	1502					

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:05 Decca Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ester Peake ambrid 7. Age (In yrs. last birthday) Year If Under 24 Hrs. Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 👿 F Months Days (Month, Day, Country) Director Usual Residence of Decedent items 23a or 28a-f show 10a. State 10d. Inside City Limits 10c. City, Town or Location death with the Maryland Examiner must be notified at Director 1 Yes 2 No Or 10e, Street and Number 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates Black Specify: 3 ₩Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) esidence , vate InrKer injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Creek Rd. nna anokei MD_{i} Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
New Revived Ceme 20c. Location City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 23/10 Taylors Island 4 Donation 5 Other (Specify) 22. Name and Address of Heility Henry Funckal 21. Signature of Funeral Service Licensee HOME MD:21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final set and Death Physician/ demontiz disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine -transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician a sthe burial-i Physician/Medical Box 68760 aftending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Pregnant at time of death 2 No ed by the a detached f 9 Unknown 9 Unknown P.0. s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Vaccular accident 2 XNo 3 ☐ Probably 4 ☐ Unknown Records, 1 🗌 Yes 24a. Was an Were autopsy findings available prior to completion of cause of has le 2 page this certificate 2 🗌 No 1 TYes 25. Was case referred to medical examiner? Division of Vital Be funeral director, 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 📈 No <u>မ</u> 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 1 Natural 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar Bramble

dress of person who completed cause of death (Item 23a) (Type, Print)

nnson

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 4a. Facility Name (If not institution, give street and number) Sr. 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Easton Voar If Under 24 Hrs. Hospice
5. Social Security Number House Talbot 6. Sex If Under 1 Year 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 220-28-0799 Months Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits or than "natural", or items 23a or 28a-f shov Director 1 Ves 2 No Ston death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S.
Armed Forces?
1 Pres 2 No 6/4/1951
If Yes, Give
Year or Dates 5/31 195 2 2160 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of usiness/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Magnote. Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing echanic 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ဂ Samue Kobert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roxine Imer 25 Mer 2 5 798 Dawso 20b. Place of Disposition (Name of cemetery, crematory or other place) DawsonSt. Royal Oak, M.D. 216
Date 20c. Location - City or Town, State 21662 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Veteran's Cemetery 21. Signature of Funeral Service Licensee 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final MD. 21613 Approximate Interval Between Onset and Death Immediate Cause (Final Abdomnal 0/05/2 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Dav 5 Other (specify) the 9 Unknown 9 Unknown signed by the detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 100 certificate 1 □ Yes 1 ☐Yes 2 ☐No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Wother (Specify) Hospice 140 Se Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Hatural 2 ☐ Accident 1 ☐Yes 2 ☐No after death

Director: / Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier

within 2 To the I State

Registrar

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

Jorge Horacio Abrego-Garcia

29c. License number
0 0 7 5 1 / 3 2

598 Cynwood Drive, Suite 104 Easton, Md. 21601

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 25,27,28a-f per me,g901,03/04/2010dhb

Certificate of Death

Reg. No. For State Registrar Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JAN. Yea 0950 2010 Jessica Nicole Workman Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Medical 8. Date of Birth (Month, Day, Year, 5-30-1989 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F Months Days Hours Min 220-23-6574 Director Yrs. Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Wicomico Delmar 10e. Street and Number 10g. Citizen of What Country? ò 10f. Zip Code of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be other traumatic event, the Medical Examiner must be Funeral 100 E. Pine Street 21875 USA permit, Page 1 and 2 should be filed within 72 hours after death Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Terry Lee Workman Tammy Lynn Sautter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy Broadhurst - Mother 100 E. Pine Street, Delmar, MD 21875 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-22-2010 Crematory of Delmarva! Delmar, Delaware Signature of Funeral Service Ligensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, <u>Maryland</u> 21804 23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Pnysician/ monic Medical Due to (or as a consequence of) Examiner Narcotic Intoxication Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Directo (or as a nonsequence or) Exami CERTIFICATION APPROVED BY MEDICAL EXAMINER burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death the detached g Unknown Division of Vital Records, P.O. overmicate has been signed by director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: The law autopsy Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1. Inpatient 2 ER/Outpatient 3 DOA within 24 hours after deau...
To the Funeral Director: After this and annieted filled in by the funeral di 27. Manner of Death 28a. Date of injury **Found** Day, Year) **01/19/2010** 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 🔀 No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Unknown Accident Investigation **Unknown** 6 X Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 100 E. Pine Street determined Found: Home Delmar, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one)

State Registrar 266. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

140056197

SAlisbury Md

29d Date signed (Month, Dav. Year)

CVD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 4:55 A^M 20, 2010 January Ralph Workman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Forest Hill Health & Rehab Forest Hill If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1⊠M 2□ F 93 221-05-9866 July 29, 1916 Delaware Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experient must be notflied at 1 ☐ Yes 2 XX No Director Baltimore MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with tonent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or: U.S.A. 21220 1000 Susquehanna Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced white 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Conductor Railroad 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carrie E. Moore William E. Workman ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other trainonce. 21220 Baltimore, MD Brenda J. Fischer (Daughter) 1000 Susquehanna Avenue 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 22, 2010 Delmar, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Melsons Cemetery 22. Name and Address of Facility
Short Funeral Home 21. Signature of Funeral Service Licensee Delmar,DE 13 East Grove Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) end Thought /Medical Due to (or as a conse wince of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed ettending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) signed by the 1 □ Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an autopsy performed? funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fune Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dro JANUARA D32299 21,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) marchail, Bel Air, MD 21014 31. Date filed (Month, Day istrar's Signature 32. Re State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State	of Maryla		artmen rtificat			and M	lental Hyg	U	10	04154
						Ce	lillicati	e or L	Jealii		2. Date of Deat	eg. No.		3. Time of Death
	Physicia	an	1. Decedent's Name (First, Midd Moon Gain Yee	e, Last)								Day 2/2010	Year	8:20am ^M
	/Medic		4a. Facility Name (If not institution	n ein etreet and a	ımbar)		4h Cihr	Town or	Location o	f Death	1/2/	4c. Count	of Death	0. ZUalli
	Examin	er	,			0000			ville					m 0.7637
			Potomac Valley 5. Social Security Number	6. Sex		. last birthday)		1 Year	If Under	24 Hrs.	8. Date of Birth (Month, Day,		ntgor 9. Birthr	place (State or Foreign ntry)
	Funeral Director		578-30-4427	Ж ХМ 2□ F	87	Yrs.	Months	Days	Hours	Min.	(Month, Day, 10/21/			ina
	D		Usual Residence of Decedent				1				10/21/			
	nylan how		10a. State 10b. County	,	10c. C	ity, Town or Lo	ocation						1	10d. Inside City Limits
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	er de Items	Funeral Director	11. Marital Status	Armed F		U.S. 13.	Was Deced If Yes, spec	dent of Hi cify Cuba	spanic Orig n, Mexican	gin? (Spo i, Puerto	ecify Yes or No- Rican, etc.)		ce - Amend ck, White,	
36	rs aft	by F	1 ☐ Never Married 2 ☑ Mai 3 ☐ Widowed 4 ☐ Divorce	It Yes. G	<u>≩ुज</u> ्रिNo ive Dates:		1 🗆 Yes	No No	Specify:			Specia	fy: As	sian
号	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-1 show the Madical Exertiner rast be notified at	ed	15. Decede	nt's Education		16a. Dece	dent's Usua	al Occupa	ation			16b. Kind of E	lusiness/In	dustry
75	7. nin 7. In "ni	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed) (1-4or 5+)	(Give	kind of wo DO NOT u	rk done d se retired	during most ()	t of work	ing			
2	d with	EO	12					Chef				Res	taura	ant
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Na	Ment Ment arkec	ဥ	Kan Zhong Yee								Wong			
Maryland 21215-0036	2 she and ls m		19a. Informant's Name/Relation			19b. Maili	ng Address	(Street a	and Numbe	r or Run	al Route Number	, City or Town	, State, Zip	Code)
	and tealth im 27 har t		Won Sue Yee	Spouse	20h	316 (Place of Dispo	Gibson		• An		lis, MD	21401 20c. Location	- Ciby or To	own State
20	ges 1 If of F or of		20a. Method of Disposition 1 □ Burial 2 □ Cremation	3 Removal from	State	cemetery, cre	matory or o	ther plac					•	
Baltimore,	t. Pa rtmen rtant: njury		`4 □Donation 5 □ Other (Hi	llcres						Annapo		
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Madical Exercitives must be notified at once.		21. Signature of Funeral Service								rdesty I napolis,			2, P.A.
	Physician		23a. Part1. Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition	r complications that t only one cause on	each line.	ath. Do not en		_	-			est,		Approximate Interval Between Onset and Death
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Box (The law requires that the death certiticate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		utcome of preg		~					23d. Da	ate of deliv	ery
ă	death e atte	iciai	in the past 12 months? 1 □ Yes 2 □ No	4☐Preg	birth 2 □ Fe Inant at time of]Ectopic pi] Other (sp					М	onth	Day Year
0	t the by the	hys	9 🗆 Unknown	9□ Unk	nown									
S, P	es tha igned be de	by P	Part II. Other significant condit	ions contributing to	death but not re	esulting in the u	inderlying o	ause give	en in Part I.			1.7		the cause of death?
ğ	w require been si should b	ted									1 🗆 Yı	es 2 No	3 Proi	babiy 4 Dunknown
Vital Records,	law ri as be 2 sh	ompleted									24a. Was a autops	sy .	prior to co	opsy findings available impletion of cause of
Œ		Соп									perform 1 ☐ Yes	ned? 2 No	death? 1 🗌 Yes	2 □ No
/ita	Physician: Th this certiticate ral director, pag	Be (25. Was case referred to medic examiner?								h (Check only on			
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Ä	ding F h. Atter tunera	lon	27. Manner of Peath 1 Natural 5 Pend	ng (Mo	of Injury nth, Day Year)	28b. Time of Injury	M	28c. Injun Work			28d. Describe ho	ow injury occu	rred	
isi	Attanding r death. actor: Attel by the tune	icat	3 Suicide 6 □ Could		e of Injury - At	home farm st			103 20		28f. Location (Si	treet and Num	ber or Run	al Route Number,
Division of	or Attano after deatl Diractor: in by the	Certification:	4 Homicide deten	nined 286. Flag	ding, etc. (Spec	city)	1001, 140101	y, om.oc			City or Town			
	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely tilled in by th	edical C	(Check only 2 Medica	ng Physician: To the	basis of exami	nowledge, dear nation and/or ir	th occurred	at the tin	ne, date an pinion, dea	id place, ith occur.	and due to the c	ause(s) and m late and place	anner as s , and due t	stated. to the cause(s)
	To tha within 2 To tha complet	Med	one) 29b. Signature and title of certifi		nner stated.	0 -			e number			9d. Date sign	ed (Month,	Day, Year)
	£ ≱ ⊨ 8) Ime	udle	mal	100		D33	826	52		Jan 2	12 1	2010.
5			30. Name and address of person	who completed ca	use of death (It	em 23a) (Type						5-000)	-
1	45		Anurita Mendhi	ratta, M.	D. Ste	330 240	1 Res		ch Bl	vd.	Rockvill	e, MD	20850)
	Sta Registr		31. Date filed (Month, Day, Yea,	25 2010 ³²	Registrar's Sig	nature .	bar	4						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death カバス 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 23, Physician/ 2010 rear Zagrodnichek 10:04 pM Leonard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 100 Civista Medical Center LaPlata Charles If Under 1 Year _ If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🛛 M 2 □ F Months Days Hours Min. (Month, Day, Year) Feb. 2, 1956 B 219-72-3922 53 Director Pennsylvania Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a, State 10c. City, Town or Location the Maryland the Medical Examiner must be notified at Director 1 Yes 2 X No Charles Maryland Nanjemoy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with t Funeral items 23a 20662 3200 Grayton Lane U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Deceden 2... Armed Forces? 1 ☐ Yes 2 ▼ No Black White etc. "natural", or þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Mechanic Be filed permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Zagrodnichek Gertrude L. Nagg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3200 Grayton Lane, Nanjemoy, James Zagrodnichek Md.20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Jan 1 Burial 2 Termation 3 Removal from State 4 Donation 5 Other (Specify) 28. Alexandria, Virginia Metropolitan Funeral Service 21. Signature of Funeral Service Lice Name and Address of Facility P.A. Head, Williams Funeral F 4270 Hawthorne Rd Home, M00668 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 2 Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate
Cause (Disease or iinjury
that initiated events Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) physician a s the burial-t Physician/Medical Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy 2 K No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA e river in 24 hours after deau... the Funeral Director: After th 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No Natural injury 5 Pending ☐ Accident ☐ Suicide Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined Medical 1 🔲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, D0050883 1/25/10 and address of person who completed cause of death (Item 23a) (Type, Print) 65 WINC 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

marria

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Of Mary I	Ce	rtificate of L	Death	Reg	.No. 2010	04130					
	Physicia	ın	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year 25 2010	3. Time of Death					
	/Medic	al	Robert Winston Ziem 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		anuary	25 2010 4c. County of Dea						
	Examin	er	16651 Spielman Road			play		Washington						
	Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)		If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day, Yept. 22, 1	(ear) 9. Bir	thplace (State or Foreign ountry)					
١.	Director		498-20-1625	5 Yrs.		S	ept.22,1	.924 N	Missouri					
	ow III			. City, Town or Lo	ocation				10d. Inside City Limits					
	a-fsh	cto	Maryland Washington		Fairp	olay			1 ∐Yes 2 X No					
	or 28	Directo	10e. Street and Number		10f. Zip Code		10g	. Citizen of What C	ountry?					
	ath w		16651 Spielman Road		2173			USA						
	ter de	Funeral	11. Marital Status 1 □ Never Married 2X Married 12. Was Decedent Ever in Armed Forces? 1 X Yes 2 □ No	1943-1		spanic Origin? (Spec n, Mexican, Puerto R	ican, etc.)	14. Race - Am Black, Whit						
215-0036	al", or	ρ	If Ves Give	1946	1 □Yes 2X No	Specify:		Specify:	White					
2-0	72 ho	etec	15. Decedent's Education (Specify only highest grade completed)	i (Give	dent's Usual Occupa	luring most of working		b. Kind of Business						
2121	filed within 72 hours after death with the Maryland Hygiene, When than "natural", or items 23a or 28a-f show ant, the Medical Evamina markes notified at	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retired, nemical En			Govern	mont					
Ω Ω	be filed vital Hygid of other event, it	BeC	17. Father's Name (First, Middle, Last)		lenitear Bi	18. Mother's Name	(First, Middle, Ma		menc					
<u>lan</u>	o g t o	To B	Henry Walter Ziem			Ollie E	lsie Da	niels						
ary	d 2 should th and Men 7 is marke traumatic		19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street a	and Number or Rural	Route Number, 0	City or Town, State,	Zip Code)					
é) (b)	s 1 and if Health item 27 other tr		Ruth Ziem - Wife	1665]	Spielman	Rd. Fair	play, Ma	ryland 2	21733					
פֿר			1 Buriai 2 Al Cremation 3 Hemoval from State		osition (Name of matory or other place	i	İ	ŕ						
Baltimore, Maryland	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Specify) S 21. Signature of Paneral Serves 1 × see			ory Jan.27 NeralityHome		ithsburg,	Maryland					
Ba	and be be be be be be be be be be be be be		Sulf & Mu			cocheague		iamsport,	MD 21795					
			23a. Pary Enter the disease, or complications that caused the disease, or heart failure. List only one cause on each lin.						Approximate Interval Between					
U T	hysician		Immediate Cause (Final disease or condition resulting in death) a. Lue to (or as a consequence of): Severe correct and Death Description of the conditions of the condition											
	/Medical Examiner													
		ē	Sequentially list conditions, if any, leading to immediate b. Severe Due to (or as a con											
	outed ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Entler Underlying Cause (Disease or injury that initiated events		<i>V</i>	*								
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68760,	rincate be executed ng physician and as the burial-transit	edical	d											
		-	F FEMALE: 23c. If yes, outcome of pre					23d. Date of de	elivery					
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Ś	e law requires that the of has been signed by the je 2 should be detached	þ	Part II. Other significant conditions contributing to death but not	1	en flow ;	en in Part I.	1 ☐ Yes		o the cause of death? Probably 4 🗆 Unknown					
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ğ K	ne lav re has age 2	Completed	hyper lipidemia,				autopsy performe	prior to	completion of cause of					
		Be C	25. Was case referred to medical			26. Place of Death		2NO 1 LIYe	s 2 □No					
	ding Physician: h. After this certific funeral director,	일	examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 ☐ ER/Outpatie	nt 3 DOA Othe	er: 4 🗆 Nursing Hom	ne 5 Residen	ce 6 ☐ Other (Sp	ecity)					
ביים	ang P	ioi	27. Manner of Death Natural 5 ☐ Pending (Month, Day, Yea	ar) 28b. Time o	Work	?	8d. Describe how	injury occurred						
Division of	ten leat tor: the	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A	At home, farm, st		Yes 2□No	8f. Location (Stre	et and Number or F	Rural Route Number,					
2	pred or Ar curs after of eral Direct filled in by	Certification:	4 ☐ Homicide determined building, etc. '(Sp	pecify)			City or Town,	State)						
	Io the Hospital of At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier (Check only 2 Medical Examiner: On the basis of examiner)	knowledge, dea mination and/or in	th occurred at the tin	ne, date and place, a pinion, death occurre	and due to the cau	use(s) and manner a	as stated. le to the cause(s)					
	vithin 24	Medical	one) and manner stated. 29b. Signature and title of certifier		29c. License									
	2 3 12 8		Krons		29d. Date signed (Month, Day, Year) 01-26-2510 Hagerstown MD 2174									
,			30. Name and address of person who completed cause of death	(Item 23a) (Type,		6940	. 1	~6						
İ	18+1		W. E. Kutzera, MO 13424	t Penn	sy/Vania	Avenue	Hage	erstown	MO 21742					
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's S	ugnature	~									

Please Type or Print in Black Indelibie Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 2130 ANDRZEJEWSKI MICHAEL 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** UNIVERSITY OF MARYLAND MEDICAL CENTER Baltimore CITY If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 9/17/1955 Birthplace (State or Foreign Country)
 MT 7. Age (In yrs. last birthday) Social Security Number **Funeral** 100M 2□F Months Days Hours MD 217-710-258 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 24 ☐ No Directo Odenton MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21113 USA 371 Baltimore Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 致放 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married XX Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Paper Laminates 12 Forklift Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be to ment of Health and Mental ant: If item 27 is marked or Maria Kline Francis Andrzejewski Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Odenton, MD 21113 Timothy Andrejewski Son 371 Baltimore Ave. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Itel
any Injury or oth 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 2/1/2010 Atlantic Crematory Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Suneral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sati 12 Ridgely Ave. Annapolis, MD 21401 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Intracranial Hemorrhage /Medical resulting in death) Examiner teriovenous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner (or as a consequence of) The law requires that the death certificate be executed and as the burial-trai resulting in death) Last Due to (or as a consequence of) Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Ö detached 9 Unknown ۵. signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ pe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe has certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 X No Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day, Year) 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DEA: AU41764355100040 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BE, MD 225. GREENE ST. BALTIMORE, MD 21201

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January, Day 19 2010 Physician/ Frederick Mason Alson Jr. 5:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 108 Clay Street Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Yea 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Country) Director 578-42-4960 1931 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene.
item 27 is marked other than "natural", or items 23a or 28a-f shou other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Annapolis Mary1and 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 108 Clay Street 21401 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Y Yes 2 □ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4X Divorced Year or Dates.Korean 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) 3yrs Building Construction Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Frederick M. Alsop Sr Martha R. Chinn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer D. Alsop(Daughter) 127 Huckleberry Dr. La Plata, Md. 20646 Baltimore, Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Date cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State Metro Crematory 1 - 26 - 10Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21 Marne and Cosse F SlitySons Mortuary, P.A. 21. Signature of Funeral Service Licenses 821 West St. Annapolis, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ard disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Pregnant at time of death Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy 1 ☐ Yes 2 ☐ No Yes or Attending Physician: after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? $5 \square$ Pending Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State To the Hospital or within 24 hours aft To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practionar T, the basis of my knowledge death continued at the time date and place, and due to the cause(s) and manner stated. (Check 050016

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month,

32. Registrar's Signature

888 Bestante

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month P^{M} Dorothy June Arey February 1, 2010 5:15 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Wilson Health Care Center Montgomery Gaithersburg 5. Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 166-20-4164 1 □ M 2 😾 F 84 June 10, 1925 Pennsylvania Usual Residence of Decedent 10b. Count 10c. City. Town or Location 10d. Inside City Limits Maryland Montgomery Darnestown 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16040 Bonniebank Terrace 20874 United States 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No Specify. Specify: White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Byron Lee Gleckner Emma Naomi Uhlman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott L. Steininger (Son) 16040 Bonniebank Terrace, Darnestown, MD 20874 20b. Place of Disposition (Name of cametery, crematory or other place)
Metropolitan 20a. Method of Disposition Date 20c. Location - City or Town, State February 2, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Crematory 2010 Alexandria, Virginia 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home, M00689 10 E. Deer Park Drive, Gaithersburg, MD 20877 Approximate Interval Between Onset and Death Due to (or as a consequence of): Metastatic liver disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Adencenteins ma, origin Due to (or as a consequence of):

Physician /Medical Examiner

permit. Pages 1
Department of H
Important: If itel
any Injury or ott

Physician

/Medical

Examiner

Funeral

Director

Show

items 23a or 28a-f short reset be notified.

death

filed within 72 hours after

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within 72 hours afte ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or i ury or other traumatic event, I'm Medical Exami

Director

Funeral

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Completed

Be

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Inneral director, page 2 should be detached for use as the burnal-transit Physician/Medical ģ Completed certificate has birector, page 2 sl Be Medical Certification: To

Division of Vital Records, P.O. Box 68760,

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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome of pregnance 1 Live birth 2 Feta 4 Pregnant at time of 9 Unknown	al death 3 Ectopic	c pregnancy (specify)		23d. Date of delivery Month Day	Year
Part II. Other significant conditions of Chalcery tites	. Chole lith	axex.	g cause given in Part I.		use contribute to the cause	e of death?
Shunt for me					24b. Were autopsy find prior to completion death?	n of cause of
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ I	Other	ath (Check only one) Home 5 ☐ Residence	6 ☐ Other (Specify)	
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur		
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factory)	ory, office	28f. Location (Street an City or Town, State	nd Number or Rural Route)	Number,
29a. Certifier 1 ✓ Certifying Ph (Check only one) 2 ☐ Medical Exar	ysician: To the best of my kno niner: On the basis of examina	wledge, death occurre	ed at the time, date and place on, in my opinion, death occ	e, and due to the cause(s urred at the time, date and) and manner as stated. d place, and due to the car	use(s)

29c. License number

04115

29d. Date signed (Month. Dav. Year)

tebruary, 2010

State Registrar 29b. Signature and title of certifier

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20/ QUSSCLL 4 VENUE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 10e per fh 9900 2-19-10 vt
State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Melva Sybil ABRAHAM Physician/ 2010 12:25 PM Januarv Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Montgomery General Hospital
Social Security Number | 6. Sex | 7. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. Age (6. Sex | 17. A 01ney 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)
Washington, DC 1 □ M 2 🗓 F (Month, Day, Year, Months Davs Director 577-22-8349 1922 Usual Residence of Decedent show or 28a-f shown notified at 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland 10d Inside City Limits Director Maryland Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f, Zip Code 5 10g. Citizen of What Country? ms 23a or must be r 3200 N. Leisure World Blvd., #702 Funeral 20906 United States er than "natural", or items the Medical Examiner mus 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 【☐ No Specify: If Yes, Give Year or Dates white 3 Nidowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Magones. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname)
Rose Belin 17. Father's Name (First, Middle, Last) ပ္ Herman Alisberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Abraham, Son 10241 Wesleigh Drive, Columbia, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Lebanon Cemetery : 01/27/10 Mt. Adelphi, MD Torchinsky Hebrew Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pneumonia disease or condition resulting in death) Days Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 1 ☐ Yes 2 Interpretation Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Modules consistent with neoplasm 1 Yes 2 No 3 Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: Other: ြို 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the pasts or examination allows investigation, in this opinion, beautiful and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 25 10 12010 H0065661 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101 Prince Philip Dr., Olney, Hospital Olver Cereral Stern, D.O. Westgoneer burch 31. Date filed (Month, Day Year) JAN 28 2010 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 20 l°0 January 9:50 PM Ruth M. Abbey /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bedford Court Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, oct 23, 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Hours 1 □ M 2 🔀 F Days 1906 Oct Director 103 102-32-8924 Usual Residence of Decedent death with the Maryland fshow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho Director 1 ☐ Yes 2 ☐ No MDMontgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20096 U.S.A. 3700 International Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status 1 ∐Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐Yes 2 🛣 No Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 ماه filed سان. ۲۰ Hygiene. ۲۰ than "r Elementary/Secondary (0-12) College (1-4or 5+) Public School 4 School Teacher marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Be John Mikola Ida Loesser ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2707 Unicorn Lane, NW, Washington, DC 20015 Richard Abbey/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/1/2010 Maimonides Cemetery Brooklyn, New York 21. Signature of Funeral Service License Melissa Greenhut | 22. Name and Addre Edward Sagel Funeral Direction, Inc. MCGreenhas M01597 1091 Rockville, Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Atrial Fibrillation , /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical the yes, outcome of pregnancy

Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 🛣 No signed by the a P.O. 9 Hinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 Hypertension 1 ☐ Yes 2 ☐ XNo 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2: autopsy performed Hospital or Attending Physician: The certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 🙀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔼 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. 28d. Describe how injury occurred After Injury at Work? 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No after death.

Director: / 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in

State Registrar

Medical

29a. Certifier (Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Wilkerson Ninala,

JAN 2 9 2010

DHMH 17 Rev 1/2001

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and manner stated.

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D45285

344 University Blvd. W Suite 113, Silver Spring, MD 20901

29d. Date signed (Month. Dav. Year)

January 26, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	•		Registrar 1. Decedent's Name (First, Middle	, Last)		Ce	rtificat	OID	eatn		2. Date of De	Reg. No. C U U U T U C Death 3. Time of Death				
Physic Me	cian. dica	1	ARTHUR V. AL			R.					Month O I	Day	Year 20/0	10/04	₽ M	
Exan	nine	r 4	Ia. Facility Name (if not institution) Anne Arundel	-	,	_			Location of	of Death			ty of Death Arun	do 1		
Funer	el	5	5. Social Security Number	6. Sex		yrs. last birthday)	If Under	apol 1 Year	If Under	24 Hrs.	8. Date of Bir		т	lace (State or	Foreian	
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Maryland 2 should be filed h and Mental Hy 7 is marked oth traumatic event	Ę	H	Conrad A. Alb						Bess	ie M.	Hines					
			19a. Informant's Name/Relationsh William C. Alb		n	19b. Mail 151	ing Address 0 7 Na i	(Street ar	nd Numbe Lan	er or Rural e, Bo	Route Numbe Wie, M	r, City or Town, ID 20716	State, Zip C	iode)		
		2	0a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 Pamoural from		Ob. Place of Disp cemetery, cre	osition (Nan	e of ther place	,		ate	20c. Location	- City or To	wn, State		
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baltimo permit. Page Department Important: It any injury or	ouce	1	21. Signature of Funeral Service L	icensee Mil	hall	2	Porrek 1 000	deddes Inive	ocor ersit	lins y Blv	Funera	l Home Silver	Inc. Spri	ng, MC	2090	
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enysiciai		ı	Immediate Cause (Final disease or condition	_a Pr	BABL	E ACI	ITE	MYO	CARD	IAL	INFAR	CTION		Onset and D	eath	
Medic Examine	_		resulting in death)	Due to	or as a co	nsequence of):										
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ate be executed only sician and the burial-transit	dical Examiner		resulting in death) Last	Due to	or as a cor	nsequence of):										
cate b	l pe			d									\pm			
eath certifical	2	1 2	F FEMALE: 3b. Was decedent pregnant	23c. If yes, out	come of pr	egnancy Fetal death 3	□ Estable =					23d. D.	ate of delive	ry		
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at the ed by t			Part II. Other significant condition	ns contributing to d	eath but no	ot resulting in the	underlying o	ause give	en in Part I		23e. Did to	bacco use con	tribute to th	e cause of de	ath?	
requires that the deribers signed by the should be detached	yd be										1 🗆 '	Yes 2 No	3 🗆 Prob	ably 4□U	nknown	
e law requires e has been sig ge 2 should b	Completed										24a. Was			sy findings av		
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g Phys g Phys er this	P _E		1 ☐ Yes 2 🔀 No 7. Manner of Death	28a. Date	of injury	2 ER/Outpatie		A Circles	4 ∟ Nu			lence 6 Oth				
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or Attendir after death. Director: Af in by the fu	Certificate:		3	nod 28e, Place	of Injury ng, etc. <i>(Sp</i>	At home, farm, stopecify)	eet, factory	office		28	3f. Location (S City or Tow	treet and Numb n, State)	per or Rural	Route Numbe	ır,	
spital hours a ineral C	Medical		29a, Certifier 1 Certifying	Physician: To the b	est of my k	nowledge, death	occured at	he time, o	date and p	place, and	due to the ca	use(s) and manr	ner as stated	i.		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	N S		only one) 3 L Certifying	kaminer: On the bas Nurse Practioner:	s of examil o the best	nation and/or inves of my knowledge,	death occun	ed at the	time, date	curred at the and place,	and due to the	e cause(s) and m	nanner as sta	ted.	ner stated.	
P 3 P 8 J			9b. Signature and title of certifier	1			29c.	License	number	-2		29d. Date signe	ed (Month, E	ay, Year)		
- IUt		3	0. Name and address of person v	nho completed caus	e of death	(Item 23a) (Type,	Print)		VY				- , / (
			Timothy U.	Constacle a	s 201	7 Tideu	rater	Colar	y Dr	#1-1	4, Au	nepolis	MD	21401		
S ⁱ Regis	tate trar	3	1. Date filed (Month, Day, Year) JAN 29 20	10 32. R	egistrar's S	ionature	1		Į.			1				
				John J.												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mark Houck Abernathy 15 PM 2010 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City Jown, or Location of Death **Examiner** 4c. County of Death COF STAL HOSPICE AT THE LAKE LISBUR Comico 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Months | Days | Hours | Min. | Sept. 20,1947 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F **Director** 242-74-7696 North Carolina 62 Usual Residence of Decedent items 23a or 28a-f shov 10a. State event, the Medical Examiner must be notified at Director 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland | Wicomico 1 X Yes 2 ☐ No Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 1009 Bayshore Court USA hours after death 12. Was Decedent Ever in U.S. Armed Forces? Years Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò ģ 1 Never Married 2 X Married 5-0036 1 ☐ Yes 2 X No Specify "natural", Completed 3 Widowed 4 Divorced Unknown Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) be filed within 72 Construction permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Equipment Salesperson Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Hubert Coleman Abernathy Ennis Houck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1009 Bayshore Court, Salisbury, MD 21804 Jeri Lynn Abernathy/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1
Burial 2
Cremation 3
Removal from State 1/25/2010 4 Donation Crematory of Delmarva Delmar, Delaware 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility. Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, Ren MD 21802 Par 1. Enter the disease, or shock, or heart failure. List o Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition URAJE Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown the hed 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy 2 X No 1 🗌 Yes 2 🔀 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: ဂ္ 1 🗌 Yes 2 X No 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completed filled in by the fu 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 L 3 D only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 01-24-2010

DHMH 17 Rev 7/2009

Registrar

BERNA

M.D.: 5302 CHINABERRY DR., SALISBURY, MD 21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BELLOSO

GREGORIO

JAN28

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DERSO N 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5000 Yorkville Road Temple Hills Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Kansas (Month Day, Months Hours 577-68-8664 Director 92 Jan Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland 1 🗌 Yes 2 🔀 No Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5000 Yorkville Road 20748 United States 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give marked other than "natural", Specify: 3 X Widowed 4 ☐ Divorced Completed White Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Fred W. traumatic Emerson Elizabeth Holaday and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .8 and 2 s Health Carol J. Anderson/daughter 5000 Yorkville Road Temple Hills, Maryland 20748 injury or other item Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 Important; If it any injury or o cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Final Journey Crematory 2/2/2010 4 Donation 5 Other (Specify) Woodbine, Maryland 21. Sign are of Funeral Service Licensee 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, M Thomas M00957 uanta 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician at the burial burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death the 9 Unknown 9 Unknown P.O. been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hospital or Attending Physician: The law cate has page 2 s performed certificate Yes 2 No 2 No 1 Yes director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ပ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural iniury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Lecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar 29b. Signature and title of certifie

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tho completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

29d_Date signed (Month, Day, Year)

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	Physicia Medi		1. Decedent's Nam Frederi	ck P · A	•						2. Date of De Month Feb.		3 20°	ar L 0	3. Time of Death 11:45a	
	Examir	ner			give street and number)				Location of Death			c. County of D	eath		
-1			38 Linto						Port Deposit Cecil If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9 Birthplace (State or)							
Ь	Funeral Director		5. Social Security N 216-62-6	143	5. Sex 1 XM 2 D F	Age (In yrs. Ia	54 Yrs.		year ays	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Da Aug • 3	rth ay, Year) 30,	1955	Birthpla Countr	ace (State or Forei	gn
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7	Mar. 28a- notifie	Director	MD	Ceci1		Po	rt Dep			<u> </u>				Ш.	1 🗆 Yes 2 🗔	No
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	ath w	Funeral	38 Linto	n Kun	Rd.	t Ever in II S	13 1	219		panic Origin? (Spe	orify Vac or No.		USA 14. Race - A	*	- Indian	_
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	and 2 Healt tem 2		20a. Method of Disp		,116	20h P	-	sition (Name o		Rd. Por	r Depos	_	MD 219		n State	
altimore,	permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tr once.			Cremation 5 Other (Sp	B ☐ Removal from Sta	te c	emetery, cren	natory or other	r place	2/5/2 Home, P	2010 • A •	1	ising S			
Balt	permit. Depart Import any inj		21. Signature	al Service Lid	epee // //		l R	Name and A	ard	Funera1	Home,	P.A	· vm 010	\ 1 1		
			23a. Part 1. Inter t	he disease, or o	omplications that caus ly one cause on each li	ed the death	n. Do not ente	er the mode of	Que, f dying,	en St. R , such as cardiac c	r respiratory a	rrest,	MD 219		Approximate	
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المستهدا	Medical Examiner		resulting in death)		Due to (or a	s a consequ	ence of):	100								_
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_	oe exe	ह्य	resulting in death) I	_ast	Due to (or a	s a consequ	ence of):									
760	icate t	ledic			d									\pm	·	
Box 68760	The law requires that the death certificate be executed rate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	23c. If yes, outcom 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknowr	1 2 ☐ Feta at time of d	Ideath 3 🗌	Ectopic preg Other (speci					23d. Date of Month		√ ∂ay Year	
s, P.O.	requires that the de been signed by the should be detached	ρ	Part II. Other signif	icant condition	s contributing to death	but not resu	ulting in the u	nderlying caus	se give	n in Part I.	23e. Did t				cause of death?	wp.
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tal	ician: The certificate rector, pag	Be	25. Was case referre		Hannibal.			2		ce of Death (Check						
fVi	Physia this c	. To	1 Yes 2	No	Hospital: 1 Inpa		ER/Outpatien		Other	4 L Nursing Ho				oe <i>cify</i>)		
o uo	Attending Physician: or death. ector: After this certific by the funeral director,	Certificate:	1 Natural 2 Accident	5 Pending Investiga	(Month, E		injury	1233.	Injury a work? 1 🔲 Y		28d. Describe I	how inju	ry occurred			
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director.		3 ∐ Suicide 4 ☐ Homicide	6 ∐ Could no determin	28e. Place of Ir	njury - At ho etc. (Spec <i>ify)</i>		eet, factory, of	fice		28f. Location (City or Tov			Rural R	oute Number,	
	the Hospital or hin 24 hours afte the Funeral Dira	Medical	29a. Certifier 1 (Check 2 only one)	Medical Ex	Physician: To the best of aminer: On the basis of luse Practioner: To the	examination	and/or invest	igation, in my	opinion	, death occurred at	the time, date a	and place	e, and due to t	he caus		ated.
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			20 Name and addition	<i>o</i>	O	dooth //	220) (7:	D D	<u> </u>	5640	19]	,	4/3//C)		
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Arias Patrick 0310 Joseph January 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Saint Agnes Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) **Funeral** Maryland **Ж**М 2□ F Months Days Hours Newborn Director anuary 27 2010 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Yes 2 □ No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Avenue 1915 States Harman 21230 United Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Mexican X Yes 2 No specify: Hispanic þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE Infant NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be finance and Mental H Be Diane Roberto 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau Baltimore Marian Diane Lake/Mother Avenue 1915 Harman Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 21230 crematory or other pract, Cathedral Cemetary SAINT 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Maryland New 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 900 CATON AVENUE BALTIMORE, MARKLAND 2022 Lynn per Delduon Long 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Prematori Extreme /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-Due to (or as a consequence of): Box 68760. Physician/Medical the attending p for use as t IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the irector, page 2 standard autopsy performed? Division of Vital 1 ☐ Yes 2 No 1 □Yes After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1**X** Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number D37452 30,2016 January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue Baltimore Maryland 21229 900 Ca ton Dr Hatoum

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Donald Edward Burke January 29, 2 or To 8:45 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Montgomery Hospice-Casey Montgomery House Rockville 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 1 X M 2 | F Months Davs Hours Sept. Day Year) Director 176-16-7815 85 1924 Pennsylvania Usual Residence of Decedent fshow 10b. County ral", or items 23a or 28a-f shor Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 14805 Pennfield Circle. #404 20906 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ 2 No WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give "natural" Completed 3 Widowed 4 Divorced Specify: Year or Dates Korea White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'amy injury or other traumatic event, the Meonee. Elementary/Seconday (0-12) College (1-4 or 5+) Special Agent U.S. Secret Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Francis Burke Edna Neureuter 19a. Informant's Name/Relationship (Type, Print)
Angela Burke/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code). 14805 Pennfield Circle, #404, Silver spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Pate Feb. cemetery, crematory or other place)
Gate of Heaven Cemetery 1 KMBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2010 Silver Spring, Maryland 21. Signature of Funeral Service Licenses Name and Address of Facility Francis J. Collins Funeral Home Inc 500 University Blvd. W., Silver Spr Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Lewy Body Dementia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? ate has b 24a Was an autopsy performed? certificate 2 No Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \sum Yes 2 **X**No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Sother (Specify) Hospice this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 28c. Injury at work? 1 ☐ Yes 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 🔀 Natural iniurv 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical 29a Certifier 1 🔽 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2511 MD33755 January 29, 2010 30. Name and address of person Bindu Joseph, completed cause of death (Item 23a) (Type, Print) MD 1355 Piccard Drive, #100, Rockville, MD 20850

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

2010

Registrar's Signature

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

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ı/	Mattie	A. Brow	m							Month Januar	D	ay 1, 20	Year	5:25
r	4a. Facility Name (ii	f not institution,	give street and num	ber)		4b. City, To	wn, or L	ocation of	Death		-	c. County		h
		ross Hos		7.4.4				Sprin		0.0 (8)		Mont		
	5. Social Security N 430-14-8 Usual Residence of	189	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. I	Yrs.	If Under 1 Months	Days	Hours	Min.	8. Date of Bir (Month, De May 23	th ay, Year) I	916	Cou	hplace (State or Intry) ansas
0	10a. State	10b. County		10c. Cit	ty, Town or Lo	ocation								10d. Inside City
Director	Maryland	Montgo	omery	S	ilver	Spring								1 🗆 Yes
	10e. Street and Nut		ood Terra	ce		10f. Zip C	904				_	10g. Citizen of What Country? U.S.A.		
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ted by	3 X Widowed	4 Divorced	If Yes, Giv Year or Da	Э		1 🗆 Yes 2						Specify:	Whi	Lte
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To Be	17. Father's Name ((First, Middle, La Nash	ast)					18. Mother's Name (First, Middle, Maiden Surname)						
			in (Tuno Print)						know		0.11			0.11
	19a Informant's Name/Relationship (Type, Print) Bryan Brown - Son Brian Brown/Son 13129 Collingwood Terrace, Silver Spri													
	Brian Brown/Son 13129 Collingwood Terrace, Silver Sp 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location 20b. Place of Disposition													
1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Takes of pisposition (Nature) cemetery, crematory or other place) Forest Hills Cemetery 01/30/2010 Alexander, Arka													Arkanga	
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, I 11800 New Hampshire Ave, Silver Spring, MD 20													
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	shock, or heart failure. Est only one cause on each line. Interval 8 Onset ar												Approximate Interval Betw Onset and D 2 week	
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Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Respiratory Failure 1 we												1 week	
cian/Medical E	resulting in death)	- 3	d								23d. Date <i>o</i> f delivery Month Day			
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 17, 2010 Physician 15:50 January Sanford M. Birnbaum /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery
9. Birthplace (State or Foreign
Country)
1915 Connecticut Holy Cross Hospital Spring If Under 24 Hrs. Silver If Under 1 Year 8. Date of Birth (Month, Day, Ye March 4, 5. Social Security Number 7. Age (In yrs. last birthday) Year) 1915 **Funeral** Days Min 1 ☑ M 2 □ F 94 Director 120-22**-**3507 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, II w Mudical Examiner must be notified at 1 Kes 2 No Director MD Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20904 U.S.A. 515 Apple Grove Road Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
14 Tyes 2 No 194
If Yes, Give
Year or Dates: 197 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1942-1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 □Yes 2 No Specify White Specify: \$ 1978 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) Biochemist 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) U.S. Public Health iene. Elementary/Secondary (0-12) College (1-4or 5+) Captain/Cancer Research permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other I any injury or other traumatic event, III. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Esther Ruth Sortman Israel Jacob Birnbaum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 910 Twin Oaks Drive Potomac, Maryland Jane Mellman/Daughter 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 【Removal from State 4 □ Donation 5 □ Other (Specify) National Crematory 1/22/2010 Falls Church, Virginia 21. Signature of Funeral Service Licensee

Or Century Melissa Greenhut
Mol597 22. Name and Addr Bath 22th sky-Goldberg Memorial Chapel, Inc 1170 Rockville Pike, Rockville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardio-pulmonary Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed Pneumonia and burial-trar Due to (or as a consequence of) Box 68760, physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) P.O. 9 Unknown ģ signed by be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Urinary Tract Infection 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should Completed Congestive Heart Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autope, performed? autonsy certificate 2 🛣 No 1 ☐ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ∐Yes 2. TNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 3 Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical npletely i (Check only one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D63343 1-20-2010 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Irina Ruban, MD 1500 Forest Glen Road Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 28 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Francis Peter Binetti 1529 January 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In vrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth

(Month, Day, Year)

July 26, 1949 **Funeral** 1 Year 9. Birthplace (State or Foreign 1 🗶 M 2 🗆 F Months Days Hours Min. Country New Jersey Director Yrs 213-54-6958 60 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 1 and 2 should be filed within 72 hours after death with the of Health and Mental Hygiene.
The marked other than "natural", or items 23a on filem 27 is marked other than "natural", or items 23a on other traumatic event, the Medical Examiner must be on the traumatic event, the Medical Examiner must be. Funeral 9727 Mount Pisgah Road. 20903 u.s.A. 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 X Yes 2 No 1968-14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: 3 Widowed 4 Divorced Completed 1972 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation oe filed with. **tal Hygiene. **er than "r 16b. Kind of Business Industry (Give kind of work done life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Goldsmith Jewelru Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Dominick Binetti Gloria Delay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Karen Buehler - Wife 9727 Mount Pisgah Rd., #613. Silver Spring. MD 20903 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 🗓 Cremation 3 🗆 Removal from State Lincoln Crematory 01/27/2010 Brentwood, Maryland 4 Dohation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 M20707 Jan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart salure. List only one cause on each line. Approximate interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Cerebrovascular Accident Medical resulting in death) Due to (or as a consequence of) Examiner Hypertension 10 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day the 9 Unknown 9 Unknown Division of Vital Records, P.O. ts been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus Type 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗶 Unknown 24b. Were autopsy findings available prior to completion of cause of death? has page performed' certificate Yes 2 X No Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospita 2 🗓 No Other: 2 1 🗌 Yes 1 🕅 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? after death. 1 Yes 2 No Accident Investigation the Suicide 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the only one) Signature and title of certifier 29d. Date signed (Month, Day, Year) 10+1 TAMMETI D39966 January 26, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Hammett.

M.D

1835 University Blvd., #226, Hyattsville, Maryland 20783

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 23, 2010^{Year} Norman Bennett 10:20A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner National Lutheran Home and Village Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Sep. 12) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F Sep. Director 578-42-5462 93 Washington DC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Hygiene. other than "natural", or items 23a or 28a-f shov ent, the Nedical Exancination traiting at MD Montgomery Silver Spring Director 1**∛**Yes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3210 N. Leisure World Blvd. 20906 U.S.A. death v by Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. filed within 72 hours after 1 X Yes 2 No 1939.
If Yes, Give 1948
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: 3 St Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other thi any njury or other traumatic event, 1 m. once. 4 Owner Appliance Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Bennett Fannie Nussbaum 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20854 19a. Informant's Name/Relationship (Type. Print) Alan Bennett/Son 9105 Wondering Trail Drive, Potomac, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/19/2010 Arlington Nat. Cem. Arlington, Virginia 21. Signature of Funeral Service Licensee Melissa 1597 22. Name and Address of Baward Sagel Funeral Direction, Inc Greenhut MCGreenhis 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Alzheimers Dementia /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): and Due to (or as a consequence of): burial-Box 68760 physician certificate be Physician/Medical the attending yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Live birth 2 ☐ Fetal death or 3
 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) O. 9 Unknown 9 Unknown Д, þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 3 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate performe 1 ☐ Yes 2 🕱 No 1 □ Yes 2 🔀 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 🙀 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 XNatural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) no D0051158 January 24, 2010

DHMH 17 Rev 1/2001

State

Registrar

108

Vatti Anthony 9707 Viers Drive, Rockville, Maryland 20850

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Departitle #901 Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 28, **Physician** John H. Bardley 2010 January 11:52 pM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 15, 1920 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Country)
Arkansas Days Min. Hours 1 XM 2 □ F 431-18-0147 89 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical France. 10a State 10h. County 10c. City, Town or Location al Hygene. I other than "natural", or Items 23a or 28a-1 snow event, the Medical Examinar must be notified at 10d. Inside City Limits Director 1 ☑Yes 2 ☐ No D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1799 Verbena Street, NW 20012 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 127 Yes 2 □ No If Yes, Give Year or Dates: WWJ 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No **Black** ģ Specify. WWII Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) DC Public Education Educator 17. Eather's Name (First Middle, Last) James Bardley Be 18. Mother's Name (First, Middle, Maiden Surname) ျ **Dreuzella** Simmons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosella M. Bardley/Wife 1799 Verbena Street, NW, Washington, DC 20012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State Jan. 3 2010 Metropolitan Crematory 4 □ Donation 5 □ Other (Specify) Alexandria, Virginia ²² Name and Address of Eacility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Sepsis days /Medical Due to (or as a consequence of) Examiner Pneumonia days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy certificate rmeg? 2 ∐No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Certification: To 1 Yes 2 No Other: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 🔼 Natural (Month, Day, Year) 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: d in by the i 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar

31. Date filed (Month, Day, Year) FEB 01

and title of dertifier

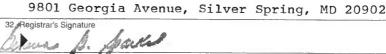
Suresh K. Gupta, MD

30. Name and address of pelson who completed cause of death (Item 23a) (Type, Print)

(Check only

one

29b. Signatur



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D32332

29d. Date signed (Month, Day, Year)

Jan. 30, 2010

Registrar

DHMH 17 Rev 1/2001

State

Hengameh Mesbahi, M.D.,11711 Livingston Road, Ft. Washington, MD 20744

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amended#31perFCHD KS 1/27/10
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ^{⊃ay}, Ward Wayne Brown 2010 7:00 p. January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Kline Hospice House Mt. Airy Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 😿 M 2 🗆 F Months Days Hours Min. (Month, Day, Country)
Maryland 220-52-1955 59 Director Dct Usual Residence of Decedent show 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 368 Madison Street 21701 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2x Married ş 2 K No Yes Baltimore, Maryland 21215-0036 **Black** 1 Yes 2XXXIII Specify: If Yes, Give "natural" 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education uld be filed with...
d Mental Hygiene...
-ad other than "r...
the Mr. 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Store Manager Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Luther Brown Ida Snowden should and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Eletha Brown - wife 368 Madison Street, Frederick, Maryland 21701 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fairview Cemetery 1-27-2010 Frederick, Maryland 21. Sign for of Funeral Service Acensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death WEEKS Physician/ SMALL BOWEL OBSTRUCTION disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner STAGE MONTHS Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 No the 9 I Inknown P.O. ed by signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s nas autopsy perform certificate 1 🗌 Yes 2 🗀 No Yes 2 No director æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? iniury 5 Pending 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of ertifie 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

THOMAS JOHNSON DR FREDERICK, MD 21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

46-B

32. Registrar's Signature

TAIMUR

SADAF

31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			-	For State Amend Registration	d #19a,1 9	State of M b, 2-3-20	aryland / 10, per	Departr	nent of l cate of t	Health and D <i>eath</i>	Mental Hy	giene Reg. No		04176
		Physicia	n/	1. Decedent's Name	e (First, Middle, Las	et)					2. Date of De	Da	ay Year	3. Time of Death
		Medic	al	Frede			rnham				Januar			1:38 P M
		Examin	er	4a. Facility Name (if				4b.		r Location of Deat	h	40	c. County of Death	
	- 4040	Funeral		5. Social Security Nu		ex 7. Ag	e (In yrs. last bii		Under 1 Year	WSON If Under 24 Hrs		th	g, Birtl	imore pplace (State or Foreign
		Director		384-56-28	340	X M 2 □ F	59	Yrs. Mo	nths Days	Hours Min.	June 1	5, Year)	1950	Michigan
		show dat	١	Usual Residence of 10a. State	Decedent 10b, County	-	10c, City, Tov	n or Locatio	n					10d. Inside City Limits
		arylar a-fst fied	ecto	Maryland	Howard			Columb						1 🗆 Yes 2 🛣 No
		the M or 28 e noti	Ωį	10e. Street and Num					Of. Zip Code	-		10g. C	itizen of What Cou	untry?
		with s 23a ust b	Funeral Director	12050 Li	ttle Pat	uxent Pkwy	Apt E		2	1044		Ur	nited Sta	ates
		death item ner m		11. Marital Status		12. Was Decedent I Armed Forces?	Ever in U.S.	13. Was I	Decedent of F , specify Cub	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No- to Rican, etc.)		14. Race - Amer Black, White	
	39	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	d by	1 ☐ Never Marri 3 ☐ Widowed	ied 2 Married 4 Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates.	No	1 🗆	Yes 2 🔀 No	Specify:				Mhite
	5-0036	hours natur lical I	Completed		15. Decedent's E	ducation	168	a. Decedent's	s Usual Occup	oation during most of wo	drings	16b. l	Kind of Business I	
	7	nin 72 Je. Shan " e Med	omp	Elementary/Seco	onday (0-12)	College (1-4 or 5	5+)	life. DO NO	T use retired,)		_	3 . 3 . 3.	
	7	d with Hygier ther t nt, th	o l	17. Father's Name (I	First Middle Last)	4		ETEC.	trical	Enginee:	me (First, Middle			vsics Lab
	and	be file ental F ked o c eve	일	Virgil		urnham				1	ine (First, Middle) Ina V.		Regener	
	Maryland	s should be filed within 72 h and Mental Hygiene. 7 is marked other than ", traumatic event, the Med traumatic			me/Relationship (7	ype, Print)	19	b. Mailing Ad	Idress (Street	and Number or Ri	ural Route Numb	er. Citv o	or Town, State, Zip	Code)
	Σ	nd 2 sl aalth a nn 27 ii		John C. John C.	Sheffer/	friend	1	2290 (1229	reen N Cree	leadow Dr 1 Meadows	Dr. Colu	mbia Tumb	MD 210)44 ₄₄ Apt. 410
	Baltimore,	je 1 ar tofH, Hiter or oth		20a. Method of Disp 1 Burial 2		Removal from State	cemet		y`or other pla		Date	20c. l	_ocation - City or	Town, State
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	Ва	permit Depar Impor any in	5)))	21. Signature of Fur	06	No.	M00957	Goil Beve	ng Home	e Cremat: • Heckrot	ion Serv	ice . Cl	P.O. Box arksvill	784 e, MD 2102 <u>9</u>
py				23a. Part . Enter t shock, or hear	he disease, or com rt failure. List only c	plications that cause ne cause on each line	d the death. Do e.	not enter the	mode of dyi					Approximate Interval Between
30	~ P	ny sicia n/ Medical	1	Immediate Cause (disease or conditio resulting in death)		a		Zizc	of	the	iver			Onset and Death
-		Examiner		resulting in death)		Due to (or as	a consequence	of):						
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0		outed nd ransit	Examiner	Cause, Enter University Cause (Disease or that initiated events	iinjury	c								
1. /		cate be executed physician and the burial-transit		resulting in death) I	Last	Due to (or as	a consequence	of):						
Tana	260	cate b physic the b	edical			d								
	687	certific nding use as	N/M	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome							23d. Date of deli	ivery
	Box	death ie atte ed for	Physician/M	in the past 12 r	No	4 Pregnant a	2 ☐ Fetal dea at time of death		topic pregnan ner (specify) _	lcy			Month	Day Year
	o :	at the		9 Unknown		ontributing to death t	out not resulting	in the under	ving cause g	iven in Part I	23a Did	tobacco	use contribute to	the cause of death?
K	o,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	d by	Tall III Gallon Signi		on a second		, , , , , , , , , , , , , , , , , , , ,			1			obably 4 Unknown
83	Records,	requi	Completed				^-^-				24a. Was			opsy findings available
FR	Sec.	he law te has age 2 s	omo								auto perf 1 🗆 Yes	ormed?		completion of cause of
		ian: T ertifica ctor, p	Be	25. Was case referre						Place of Death (Ch			101	
ALL	<u> </u>	hysio this ce al dire	욘	1 ☐ Yes 2	⊈Klo		ient 2 ER/C			4 L Nursing			Other (Speci	m Gilchrist
7.	n 0	ding F h. After funera	ate	27. Manner of Death	5 Pending	28a. Date of inju (Month, Da		Time of injury	28c. Inju wor 11 _		28d. Describe	how inju	iry occurred	
BURNHAM	Division of Vital	Attending Physician: r death. ector: After this certific by the funeral director,	Certificate:	 2	Investigatio 6 Could not be determined	28e. Place of Inj	ury - At home, f						nd Number or Rui	ral Route Number,
8	Div	tal or irs afte al Din led in				building, et	с. (Ѕреспу)				City or To	wn, Stat	e <i>)</i>	
P	1	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director, After this certificate he completed filled in by the funeral director, page	Medical	(Check 🙎	Medical Exam	sician: To the best of iner: On the basis of e se Practioner: To the	examination and	or investigati	on, in my opin	ion, death occurred	at the time, date	and plac	e, and due to the o	cause(s) and manner stated.
(3	3	To the within To the compl	2	29b. Signature and		A .	255t of my Mio	Jago, aouti	29c. Licens				ate signed (Month	
	Ó			De Pe	ue Kaw	Ky Mi)			106	8104		-	2/1/20	10
		8		30. Name and addr	ess of person who	completed cause of c	death (Item 23a)	(Type, Print)	Sil	PC 410	5. Pa	An	nove f	ND 212001
		Sta		31. Date filed (Mont	FEBU 3	2010 32. Riegistr	ar's Signature	Sac	Ked	10 110	-/ 1041		10.11	
		Registr	वा			1	1	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 02:35 AM CIGNITOR Jan 2010 Medical 4a. Facility Name if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Takoma Park Montgomery Washington Adventist Hospital 8. Date of Birth (Month, Day, Ye March 10 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Funeral Days Months Hours Min. 1 X M 2 - F Director 578-68-9677 58 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f sho er must be notified at 10d. Inside City Limits Director 1 K Yes 2 No Prince George's Capitol Heights Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 704 Brooks Road 20743 United States Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ò þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. African 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed American the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) 12th Mechanic Private of Health and Mental Hygie f item 27 is marked other r other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Percy W. Butler Ophelia Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20019 Angela Butler-Mills/ Sister # 450 Washington, DC 800 Kennilworth Ave. NE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ₽ Important: If it any injury or o 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State February Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial 2010 22. Name and Address of Facility Stewart Funeral Home, Inc. Sk nature of Funeral Service Licensee 4001 Benning Rd. NE Washington, DC 23a. Part 1) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last CHRONIC OBSTRUCTIVE SLEEP APHEA STABROME Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 4 Pregnant Pregnant at time of death 2 🗌 No ed by the a detached f 1 Yes 2 g s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Completed by neumonitis Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has be irector, page 2 s autonsv death?
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To the Funeral Director: / Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Print) BB State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. 2 U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY 31, 2010 **Physician** 2:24A GEORGE Ε. BURLEY JR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner PRINCE GEORGE LAUREL REGIONAL HOSPITAL LAUREL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours | Min. | MARCH 29 | 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign 5 Social Security Number 7. Age (In vrs. last birthday) **Funeral** Year) 1952 MARYLAND 57 579-74-2129 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show "natural", or items 23a or 28a-f sho BELTSVILLE Y⊟Yes 2□No MD PRINCE GEORGE Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20705 4504 TOMOUIL STREET Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE 3rd permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, Important: If flem 27 Is marked any injury or other the page. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MILDRED E. BUTLER GEORGE E. BURLEY SR 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6204 FOOTE STREET SEAT PLEASANT, MD 20743 19a, Informant's Name/Relationship (Type, Print) MILDRED E. BENSON/MOTHER 20b. Place of Disposition (Name of Lines fry crategy or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2-8-2010 SUITLAND, MD HILL CEMETERY 4 Donation 5 Dother (Specify) JB JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 7474 LANDOVER RD LANDOVER, MD 20785 Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease, or com shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Respiratory Immediate Cause (Final disease or condition resulting in death) **Physician** andio /Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examir death certificate be executed physician and the burial-transil Due to (or as a consequence of): Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.0. certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Ves 2 \(\tilde{\Delta}\) No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐Yes 2⊠No this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death al or Attending P 1 X Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No neral Director; A filled in by the fu investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature And title of certifie 31 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOHAMED TOURKY, MD 7300 VAN DUSEN RD LAUREL, MD 20707 31. Date filed (Month, Day, Year) 32, Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

FEB 0 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 PestaRet of Cheryland 12 20 Salton of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Feb Month 2010 Rosetta M. Brown 23**₽**15 ^M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery County 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔁 F Months Days Hours Min. (Month, Day, Year) Yrs. 577-28-4166 Director Washington, D.C. Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City, Town or Location notified at Director 28a-f 1 Yes 2 No PRINCE GEORGES MD MITCHELLVILLE ò 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n 20721 3800 Lottsford Vista Rd. United States items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinonce. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Susie Wood Cylas Wade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barry Wade / Grandson 4723 River Valley Way Bowie, Md 20721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial 4 Donation 5 Other (Specify) Feb. 8, 2010 Suitland, Maryland 21. Sign to of Funeral strvice Ligenses 22. Name and Address of Facility John T. Rhines Funeral Home, LLC 3005 12th Street NE WASHINGTON, DC 20017 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ardiovascular Disease Physician Atherosclerotic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause (Disease or linjury Due to (or as a consequence of): Exami physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) ed by the a g Unknown 9 ☐ Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 XNo certificate 1 Tes Yes funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2XXER/Outpatient 3 I DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death.

I Director: Aft d in by the fur Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical 29a. Certifier 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 5769 February 2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blud Suite 200 Germantown Md 20874 Centur -0010 J. White

DHMH 17 Rev 7/2009

State

Registrar

FFR 0 5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Lillian Lydia Brown February 1 5:25 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death St. Mary's Charlotte Hall Veterans Home Charlotte Hall 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 XXF 82 Days Hours May 8, 192 034-32-2851 South Carolina Yrs **Director** Usual Residence of Decedent 28a-f shov 10b. County 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2XX No Maryland St. Mary's Charlotte Hall 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 29449 Charlotte Hall Road 20622 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2¾☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. , or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify. 'natural", Completed 3XXWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) I Hygiene. College (1-4 or 5+) traumatic event, the 12 years Homemaker In Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental မ Page 1 and 2 should be f ment of Health and Menta ant; If item 27 is marked **Elliott** Jenkins Sr. Amelia Garner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James H. Brown Jr. / Son 3941 Light Arms Place Waldorf, Maryland permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arlington Nat. Cemetery 02/19/2010 Arlington, Virginia 22. Name and Address of Facility 21. Signatur George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 23a, Part 1, Enter the dis nors that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ase or complic shock, or heart failure. List only Interval Between Immediate Cause (Final disease or condition Onset and Death NE Physician/ UMON Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? detached for Month Day Pregnant at time of death Yes XXXVo 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CEREBRO VASCULAR ACCIDENT Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an performed? Yes 2 No CORONARY ARTERY DISEASE To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pendina 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Descripting Nurse Practiciner: To the cost of my knowledge, cost, occurred at the time, date and place, and the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) theenkas MD D0067788 2.2.2010 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

RAO

31. Date filed (Month, Day, Year)

FEB 0 5 2010

KODALI MD Charlotte Hall, Maryland 20622

32. Registrar's Signatur

10-00840 Francis Xavier Ch		1- For State Certificate of Death	Hygiene	egible. 201	0 0418
Physiciar Medical Examin	er		2. Date of De Month January	eath Day Year 29 , 2010	3. Time of Death 1414 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat 25321 Vista Road Hollywood	th	4c. County of Dea St. Mary's	th
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr 213 15 7105 1x M 2 F 33 Yrs.	n.	3 / 1 9 7 6 C	
land f show any once.	Ī	Usual Residence of Decedent			10d. Inside City Limits 1 Yes 2 No
ith the Mary		10e. Street and Number 43847 Palamino Drive 10f. Zip Code 20636		10g. Citizen of What Cou	untry?
after death w	by runeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No No specify:		White, etc.	rican Indian, Black,
5-0036 led within 72 hours. Hygiene. Other than "natura the Medical Exami	palaidi	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 th College (1-4 or 5+) Cook		16b. Kind of Business	•
MD 21215-0036 and 2 should be filed within 7 ship and 2 should be filed within 7 ship and 2 should be filed within 7 ship and 2 ship		17. Father's Name (First, Middle, Last) Francis X. Chase, Sr. 18. Mother's Name Joyce	Young	Maiden Surname)	
MD 21 and 2 should salth and Me em 27 is marraumatic ev	L	19a. Informant's Name/Relationship (Type, Print) Francis S. Chase, Sr./Father 43847 Palamino D 20a. Method of Disposition	r. Hol	llywood, M	ID20636
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1			, MD
Physician /Medical =xaminer	١,	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	aton F	TableW ds	MD20601 Approximate Interval Between Onset and Death
t xaminer		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated			
executed ian and al - transit	i "	events resulting in death) Last Due to (or as a consequence of): d. UNPENDED AMENDED			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transiedical Certification: To Be Completed by Physician/Medical E.	II 23	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify) 9 Unknown	incy	23d. Date of delivery Month	y Day Year
S, P.O. uires that the a signed by the detache		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to	
Division of Vital Records, ratending Physician: The law require rs after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be striffication: To Be Completed			24a. Was autop perfo 1 ✓ Yes	psy prior to commed? death?	topsy findings available ompletion of cause of
Physician: Prysician: er this certificant of the Corp.	2		g Home 5	Residence 6 🗸 Other	: Scene
Division of Neptial or Attending Phours after death. Teral Director: After tilled in by the funeral Certification: T	2 3	1 Natural 5 Pending Jan 29, 2010 1346 hrs 1 Yes 2 ✓ No	Passenger (now injury occurred of auto involved in o	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	(0	4 Homicide determined (Specify) Unpaved Road 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	due to the caus	e(s) and manner as state	d.
To the Howithin 24 To the Force Completed	L	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated 29b. Signature and title of certifier 29c. License number	t the time, date	and place, and due to the 29d. Date signed (Mon	

State Registrar

Jack Titus MD. Deputy Chief Medical Examiner 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

M

32. Registrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

OCME

January 30, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0820 ALDWELL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Harwood Mandrin Chesapeake Hospice House If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 2 M 2 □ F Months Hours 10 15 7 1932 California 77 Director 254-46-2112 Usual Residence of Decedent and More active the state of th 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 ☐ No Marvland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral 21401 USA 38 Murray Avenue 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces?
1 X Yes 2 □ No Black White, etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes Give 3 Widowed 4 Divorced White Year or Dates. 1955-62 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Defense Engineer 5+ vears Be Department of Health and Mental H Important if item 27 is marked of any injury or other traumatic acceptance. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elizabeth Chase Rex S. Caldwell, Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Caldwell/ Wife Murray Avenue, Annapolis, Maryland 21401 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/25/2010 Kalas Crematory Edgewater, Maryland Pof Juperal Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the d ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ROSTATE 6 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of) Exami sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached f Yes 2 No g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has b lirector, page 2 sl autopsy performe death? Yes 25. Was case referred to medical director Be 26. Place of Death (Check only one) 6 Other (Specify) examiner? Hospital Other: 2 No OSMICE ြု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral directors. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at HUUSC 28d. Describe how injury occurred 5 Pending Natural 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie pleted cause of death (Item 23a) (Type, Print) 201 ANNAPULI MOZIYUI DEFENSE 32. Registrar's Signature State 2010 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ronald Malcolm Culpepper January 31, 2010 Physician/ 8:25 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country 1 M 2 - F Months Days Hours Min. July 10, 1936 214-32-8890 73 **Director** Usual Residence of Decedent show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **23a** Funeral 807 Downs Drive USA 20904 or items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ 72 hours after Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Dates Specify: "natural" 3 Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Department of Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ E. Harry Culpepper Armida Jean Hodges 19a. Informant's Name/Relationship (Type, Print)
Joan Frances Culpepper/Wife 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 807 Downs Drive, Silver Spring, MD 20904 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State Feb. Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 Silver Spring, Maryland 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spri 21. Signature of Funeral Service Licenses Spring, MD 20901 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hypovolemic Shock disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Severe Colitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death 2 No 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 XNo 1 🗌 Yes ၉ 1 Npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 X Natural injury 5 Pending 2 🗆 No M 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D63579 February 1, 2010

State Registrar 31. Date filed (Month

Registrar's Signature

Torest Glen Road, Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 30, Day 2010 Physician/ Evelyn Whitlock Clarke 9:05a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3700 International Drive, Apt. 328 AL Silver Spring Montgomery Social Security Number if Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2⁄03 F Months Hours May 2, 1909 Virginia Director 577-22-7245 100 Usual Residence of Decedent or 28a-f show notified at death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Silver Spring Montgomery 1 ☐ Yes 2 H No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be Funeral 3700 International Drive, Apt. 328 AL 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Completed by Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify: Specify: White "natural" 3 😾 Widowed 4 □ Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. the Office Manager Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ည James Owen Whitlock Martha Walshe 1 and 2 should be of Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4544 Minuteman Drive, Rockville, MD 20853 Shirley Keller/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1:
Department of I
Important; If it
any injury or or ŏ 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 2010 Fort Lincoln Cemetery Brentwood, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee ²²Francis de Collins Funeral Home Inc. Manisa 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician Stroke disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and -trans that initiated events resulting in death) Last Due to (or as a consequence of): the burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? 1 ☐ Yes 2 ☐ KNo Day ed by the a 9 Unknown 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypoglycemia 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No this certificate 1 Yes 2 No Be 25. Was case referred to medical director, 26. Place of Death (Check only one) Hospital Other: Certificate: To 1 Tyes 2 **xx**No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director, After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, February 2, 2010 D23124 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis Hannon, MD 3300 Olney-Sandy Spring Road, Olney, MD 20832

DHMH 17 Rev 7/2009

State

Registrar

racked

32. Registrar's Signature

			For Amend Items 23	State of Maryl	and / Depa ,27 ,28 a — <i>Cei</i>	rtment of H f per me, tificate of l	lealth and N 8906,08/ Death	18/20106 R		10	04185
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Nancy M. Cafare	elli				Month February		Year	3. Time of Death 9:00 a M
6	Examir		4a. Facility Name (If not institution, give st Hillhaven Nursing Cen			4b. City, Town, or Adelphi	Location of Death		4c. County of P.G.	f Death	
	Funeral Director		5. Social Security Number 6. Sex 579–01–7199 1□	M 2 F 7. Age (In)	yrs. last birthday) 4 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Nov. 9, 1	. Year)	9. Birthpla Country [taly	ce (State or Foreign
	a-f show iffed at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland P.G.	10c.	. City, Town or Lo Hyat	cation tsville				100	d. Inside City Limits 1 ☐ Yes 2 ☒ No
:	with the	1 Dire	10e. Street and Number 818 Sheridan Street			10f. Zip Code 20783		1	I0g. Citizen of Wh	nat Country	/?
36	rs aner deaun I", or items 23 xaminer mus	by Funeral Director	11. Marital Status	2. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)			c.
21215-0036	iges I and 2 should be lifed within 12 hours after death with rife maryland it of Health and Mental Hygiene. At of Health and Mental Hygiene. or other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade		(Give	DO NOT use retired	durina most of work	sing	16b. Kind of Business/Industry Own Home		
Maryland 2	nould be med I Mental Hygi narked other natic event, t	To Be Co	17. Father's Name (First, Middle, Last) Pasquale Pompieri				18. Mother's Nam Concetta Po		Maiden Surname)	
Mary	of 2 should the and the state of the state o		19a. Informant's Name/Relationship (Typ Jason Cafarelli/Gran				and Number or Rui eet, Hyatts			State, Zip C	ode)
D III	rages I and a nent of Health ant: If item 27 i ury or other tra	Π	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re 4 □ Donation 3 □ Other (Specify)	emoval from State		sition (Name of matory or other place eaven Cemet	re) Feb	Date Dio ⁴ ,	20c. Location - C	•	
Balti	Department of Important: If it any injury or once.		21. Signature of Funeral Service License]	Name and Address Francis J. 6 500 Univers	ss of Facility Collins Fun ity Blvd.,	meral Home W,. Silve	Inc. r Spring,	MD 209	901
	hysician //Medical Examiner bhysician and street st	dical Examiner	23a. Part1. Let the dibe se, or complice shock, or leart failure. List only on the shock or learn failure. List only on the shock of th	cations hat caused the ceause on each line. Cardiac Arrh Due to (or as a con Hypertensive Due to (or as a con Coronary Art Due to (or as a con Anemia	nythmia sequence of): c Cardiovas sequence of). cery Diseas				sees a load	Trum 200	Approximate mierval Between Onset and Death Thirds. Thirds. Thirds. Thirds.
O. Box 6	the attending the attending ched for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome pf pro 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				of delivery	y Day Year
Ω.	es de de	by	Part II. Other significant conditions con Aortic Aneurysm, Tha		_		ren in Part I.		obacco use contri es 21 No		cause of death?
l Rec	ine law ate has b page 2 sl	Completed	Hip Fracture					24a. Was a autop perfor 1 Yes	sy pi rmed? de	/ere autops rior to com eath? ☐ Yes 2	sy findings available pletion of cause of 2☐ No
vision	lothe Hospitia of Attending Priystolan: In within 24 hours after death. To the Funeral Director. After this certificate completely filled in by the funeral director, pag	ertification: To Be (25. Was case referred to medical examiner? 1 Yes 2 Ho 27. Manuard 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Yea 01/13/2010 28e. Place of injury building, etc. (Sp	Unknow At home, farm, sti	f 28c. Injur Wor M 1 □	ry at k? Yes 2 X No	ome 5□Resid 28d. Describe h	ne) lence 6 □Othe low injury occurre t fell. Street and Numbe m, State) 818 ille, MD	ed	
	Hospital of the state of the st	Medical Ce		Home sician: To the best of my ner: On the basis of exame and manner stated.			me, date and place	, and due to the	cause(s) and mar	nner as sta	ited.
		Mec	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date signed		
•	6		30. Name and address of person who con Vaid Vivek, MD 3311	mpleted cause of death				20782	February	2, 2	,10
	St Regist		31. Date filed (Month, Day, Year) FEB 0.3 2010	32. Registrar's S		Kas	· ·				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:00p M 2010 Joan Shih Carducci Januaru Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14209 Sturtevant Road Silver Spring Montgomery 8. Date of Birth 12/21/1933 If Under 1 Year Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs. **Funeral** Days Min 1 🗆 M 2 🗓 F Director Yrs 515-40-8241 76 Taiwan Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must ha matrical and injury or other traumatic event, the Medical Examiner must ha matrical 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14209 Sturtevant Road 20905 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. 3 X Widowed 4 Divorced Completed Asian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Founder Cooking School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Luke Shih Lien-Chin Chang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Carducci - Daughter 13081 Wainwright Road, Highland, Maryland 20777 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 💯 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Spacify) Lincoln Cemetery 01/30/2010 | Brentwood, Maryland Fort 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee M00709 11800 New Hampshire Ave., Silver Spring. MD 20904 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Arrythmia disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 5 Other (specify) Yes 2 X No signed by the a d be detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hupertension 1 Tes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 K Residence 6 Other (Specify, 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 🗆 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatur

State Registrar Dawn Br<u>oderick,</u>

31. Date filed (Month, Day, Year) JAN 28 2010

Box 68760

P.O.

Records,

Division of Vital

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

M.D.

D45956

18109 Prince Philip Drive, Suite 275, Olney, Maryland 20832

29d. Date signed (Month, Day, Year)

January 26, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 16 2010 Carolyn Jean Calder 8:43 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Holy Cross Hospital Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 D M 2 🖰 F Hours oct. 12, Yaar 1955 214-60-7236 Maryland 54/rs Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Tes 2 No Maryland Montgomery Kensington ь 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items 23a 3000 McComas Avenue 20895 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Force Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Specify: White 3 XWidowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Clarence Nolan Carter, Sr. Helen Christine Rodgers 19a. Informant's Name/Relationship (Type, Print) Heidie Lynn Calder/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) 129 Watkins Station Circle, Apt. F, Gaithersburg, MD 20879 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Darnestown Presbyterian
Church Cemetery 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State February 1, Darnestown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Francisd Jodges Tres Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Bitter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Chronic Obstructive Pulmonary Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated as or injury) Examiner Due to (or as a consequence of). g physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🐼 No Month Day Year Pregnant at time of death signed by the a 9 Unknown g 🗌 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Artery Disease Division of Vital Records, cate has been signated by page 2 should by 1 XYes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 🛣 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 은 1 🗌 Yes 2**x** No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 SER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 1 XNatural 5 Pending work? 1 ☐ Yes 2 ☐ No after death. Accident Investigation 3 Sulcide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined building, etc. (Specify) within 24 hours a **To the Funeral D**completed filled i Medical 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D64624 January 20, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sandeep Sharma, MD 743 Summerwalk Drive, GAithersburg, MD 20878

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year) JAN 29 2010

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Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ James Samuel Cook , III January 27, 11:10 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Olney Montgomery General Hospital Mon toomery 9. Birthplace (State or Foreign Country) D. C. Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) 1941 Days (Month, Day, 1 🛛 M 2 🗆 F Director 578-54-6740 Yrs. 68 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🏝 No Maryland Montgomery Silver Spring 5 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral items 23a 3262 Gleneagles Drive 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 10 Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural", Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Manager Retail Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental I marked ျှ James Samuel Cook, II Margaret Mae Wahler permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) Kristina Lynn Cook/Daughter Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12444 Fingerboard Road, Monrovia, MD 21770 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Cedar Hill Cemetery 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 2010 4 Donation 5 Other (Specify) Suitland, Maryland 21. Signature of Funeral Service Licens Name and Address of Facility rancis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only and cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Physician/Medical Examiner quence of If any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events physician and the burial-tran Due to (or as a consequence of) resulting in death) Last Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Pregnant at time of death Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 🖾 No Other: ျှ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? Certificate: 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No. Investigation 3 Suicide 4 Homicide 6 Could not be determined

Division of Vital Records, P.O. ithin 24 hours after death.

o the Funeral Director: After th within 7 2

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 60 UD 28 10 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18404 Oxfordshire Terrace, Olney, MD 20832 Aruna K. Paspula, MD Registrar's Signat **ORIGINAL**

State

Medical

29a. Certifier

only one)

31. Date filed (Mo

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Delath 0 11:58 a M 1. Decedent's Name (First, Middle, Last) January 27, **Physician** JoAnn Caffiaux 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sanctuary at Holy Cross Montgomery Burtonsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 13, 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Min. 1 □ M 2 🔀 F 82 100-20-4916 New York Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show 1 ☐ Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified. Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13326 Foxhall Drive 20906 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Flome Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Becker Mary Zoeller ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean A. Caffiaux/Husband 13326 Foxhall Drive, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cate of Heaven Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition Feb. 2. 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Silver Spring, Maryland 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 of Funeral Service Licenses Approximate Interval Between Onset and Death plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner mcreatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of). P.O. Box 68760, attending physician Physician/Medical the the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for 1 Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signated bage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed 2 No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 ☐ Pending investigation Injury 1 Natural 1 Yes 2 No n 24 hours after death.

Pe Funeral Director: A pletely filled in by the fu death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely within 24 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 00698 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tesnien R 2835 Smith avanue, Juile 203, Ballimive Raza Juite Smith avenue, 203 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 29 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month John D. Constantine 2010 6:20 Medical January 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Berlin Nursing Home Berlin Worcester 5. Social Security Number 6. Sex 1 ★ M 2 □ F 7. Age (In yrs. last birthday) 82 yrs. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Hours 1272471927 031-12-1450 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland al Hygiene. Jother than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Be Completed by Funeral Director 1 🗆 Yes 2 🔀 No MD Berlin Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10012 Hayes Landing 21811 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. traumatic event, the Medical Examiner Armed Forces? 1 □ Yes 2 □ No If Yes, Give Black, White, etc. 1 Never Married 2 XMarried 1 ☐ Yes 2 ☐XNo Specify: Specify: white 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic General Motors 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked otl any injury or other traumatic even once. ည William Constantine May Conrad 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen Constantine / wife 10012 Hays Landing, Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cape Henlopen Crem. 1/29/2010 Frnakford, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home |108 William St., Berlin, MD 21811 23a. Part Inter he disease, or complications should, or he art failure. List only one cause inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to for as a consequence of **Examiner** standing Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury and that initiated events resulting in death) Last the attending physician To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy Medical Certificate:

Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 in 24 hours after deaun.

The Funeral Director: Aft

The fund in by the fundamental in th

Baltimore, Maryland 21215-0036

ne, John

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Colum /Co	anter	1 \(\text{Yes} \) 2 \(\text{Yes} \) No \(1 \) Yes 2 \(\text{No} \) No						
25. Was case referred to medical examiner?		26. Place of Death (Check only one)						
1 ☐ Yes 2 ☑ No	ospital: 1							
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigati 3 Suicide 6 Could not	(Month, Day, Year) injury injury M	8c. Injury at work? 1 ☐ Yes 2 ☐ No						
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e Diace of Injury At home form street factory	office 28f. Location (Street and Number or Rural Route Number, City or Town, State)						
(Check 2 Medical Example (Check 2 Medical Example)	miner: On the basis of examination and/or investigation, in n	the time, date and place, and due to the cause(s) and manner as stated. my opinion, death occurred at the time, date and place, and due to the cause(s) and manner st red at the time, date and place, and due to the cause(s) and manner as stated.						
0.00								

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9+1

Arumala,

Healthway Dr, Berlin, MD

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State

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Amended 26 & 29d per MD FCHD RGentificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 22, 2010 Dorothy J. Crowder 6:45 p. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick Jefferson 4216 Springview Court 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 6. Sex 7. Age (In yrs. last birthday) (Month, Day, Months Days Hours Min. 1 M 2 F 85 Indiana Director 309-22*-*0802 1924 Oct Usual Residence of Decedent 28a-f show 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits must be notified at Directo Maryland Frederick Jefferson 1 Yes 2x No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 23a 21755 USA 4216 Springview Court filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: white Specify: Completed 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Education Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill treent of Health and Mental tant: If item 27 is marked o မ Augusta Myles Frederick Joslyn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21755 Frances J. Raynor - daughter 4216 Springview Court, Jefferson, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)

Walnut Grove Cemetery 1-29-2010 20a, Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 K Removal from State Clinton, Indiana 4 Donation 5 Other (Specify) Signature of Funeral Service Coensee 22. Name and Address of Facility Stauffer Funeral Home 21702 1621 Opossumtown Pike, Frederick, Maryland Approximate
Interval Between
Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Esuphagea Physician/ disease or condition resulting in death) CAVUINO Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetai uea ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Day Month Year signed by the at d be detached fo 9 🗌 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 2 No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 2 (ZINO 1 Yes 4 ☐ Kursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending thin 24 hours after death. Matural 5 Pending work? 1 Yes 2 No Accident Investigation Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 006793 MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21702 46 Thomas Johnson Drive, Frederick, Maryland MD Sebastien Kariouz, 31. Date filed (Month, Day, 32. Registra 's Signature State Darke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

ype or Print in Black Indelible Ink. Ensure All Copies Are Legible. William Chaney State of Maryland / Department of Health and Mental Hygiene 2010 04192 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death William Chaney 2010 hrs Medical Examiner January 9, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center **Baltimore** 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign MD Country) 220-40-9591 Months Davs Hours Min. Director 10/27/1945 1 **X** M 2 F 64 Usual Residence of Decedent any 10a, State 0c. City, Town or Location 10d, Inside City Limits 10b, County MD Frederick Mt Airy 1 Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5302 Dove Drive 21771 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 Married 1 Yes Specify: White 1 Yes 2 X No specify: 3 Widowed 4 X Divorced If Yes, Give Year ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 Fire Fighter Montgomery County 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) James Carlton Chaney Anna Beatrice Crowther 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles L. Chaney - Son 13127 Graceham Road, Thurmont, MD 21788 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Stauffer Crematory Inc. 01/14/10 Frederick, MD 4 Donation 5 Other Specify. 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee per DVR Todd D. Wynn 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Intracerebral Hemorrhage Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b. Stroke Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause c. Carotid occlusion Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and AMENDED #21 per fh,g901,03/15/2010dhb UNPENDED attending physician or use as the burial Box 68760, IF FFMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Physici 5 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ģ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed certificate has been sector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? Yes 2 V No 2 No 25. Was case referred to medical 26 Place of Death (Check only one) æ Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other DOA After this 1 Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 V Natural 5 Pending 1 Yes 2 No death. the Director: 2 ___ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined within 24 hours a the Hospital 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 😿 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29h Signature and title of certific 29c. License number 29d, Date signed (Month, Day, Year) OCME March 12, 2010 Valle 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. R gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Josephine Mary Citrano January 3:10 PΜ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Mt. Airy Frederick 7520 Woodville Road . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 3, 9. Birthplace (State or Foreign Country) Maryland 6. Sex **Funeral** 1 ☐ M 2 🖾 F Months Days Hours Min. Yrs Director 578-28-5935 88 Aug Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director er than "natural", or items 23a or 28a-f sl, the Medical Examiner must be notified 1 XYes 2 No Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3909 New Haven Court, Apt B10 20716 United States 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Specify: Completed 3 XWidowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home is marked other other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Minor Mabel Lillian Taylor George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Nancy E. Sipe/daughter 4011 Buchanan Street Hyattsville, Maryland 20781 Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 🗋 Burial 2 🕱 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 2/3/2010 Woodbine, Maryland 21. Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Thomas unita M00957 <u>Beverly L. Heckrotte,</u> P.A. Clarksville, MD 21029 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MONTHS Immediate Cause (Final Physician, Metastatic Ovarian Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Union, if Cause (Disease or iinjury Due to (or as a consequence of): Exami and-train that initiated events resulting in death) Last Due to (or as a consequence of): burial attending physician for use as the buria Physician/Medical law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo Pregnant at time of death 5 Other (specify) Month Day Year the 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown P.O. been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Congestive Heart Failure 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Atrial Fibrillation 24a. Was an cate has I page 2 s autopsy performed? Physician: The certificate Cancer of Rectum 2 🔀 No 1 Tes 25. Was case referred to medical examiner? Division of Vital director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Spec Hospital: Daughters 1 ☐ Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this Residence funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of al or Attending P s after death. I Director: After t d in by the funera Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 124 hours atte ne Funeral Dir npleted filled in Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State

To the I within 2 To the I complex

(Check

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) FEB 0 3 2010

Loward / Cullen W

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edward T. Cullen, M.D. 6188 Oxon Hill Road

Registrar's Signature

Registrar DHMH 17 Rev 7/2009 arke

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0026607

Oxon Hill, Maryland 20748

29d. Date signed (Month, Day, Year)

February 1, 2010

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Death Physician Year COX MICHELLE TAMT 1850 М /Medical JANUARY 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 962 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🏝 F 47 Director 215-90-4857 WASHINGTON DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Funeral Director MD PRINCE GEORGE'S MITCHELLVILLE 1 TXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3704 BASKERVILLE DRIVE 20721 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ∐Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 🛣 No Specify: BLACK 3 Widowed 4 Divorced or than "natur. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CLERICAL PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be If item 27 is marked or other traumatic ev MITCHELL COX EUNICE HOLLOMAN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EUNICE COX/MOTHER 3704 BASKERVILLE DRIVE MITCHELLVILLE, MARYLAND 20721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ott 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State HARMONY CEMETERY 2/6/2010 LANDOVER, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or repirator only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions. Examiner d any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed burial-tran and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 Live birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. I the 9 Unknow been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 of Vital 1 ☐ Yes 2 ☑ No 1 □ Yes 2√No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2×100 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Certification: To 1 ☐ Yes 1 🔲 Inpatient 2 XER/Outpatient 3 ☐ DOA After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 X Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation I Director: A death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide hours after within 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the course of the course o Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of pertifie 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

DEMETRIOS

31. Date filed (Month, Day,

3001 HOSPITAL DRIVE CHEVERLY, MARYLAND 20785

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CATEVENIS M.D.

JAMES

Year)

FEB 0 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ James C. Constandino 2010 6:41 РМ January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Southern Maryland Hospital Clinton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 ፟M 2 □ F Months Days Hours Min. 017-18-1292 Director 87 Albania Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Tes 2 No Clinton MD Prince George's 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20735 USA 6326 Manor Circle Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 X Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give WWII
Year or Dates. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 th and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Andrews Air Force Base 4 Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Christos Constandino Efdoxy Millios Department of Health an Important: If item 27 is n any injury or other once 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Backus / niece 14730 Laurelwood Lane Silver Spring, MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 2/3/2010 Franklin Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Franklin, NH 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 23a. Pari 1. Enter ne disease or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to lo as a consequence of **Examiner** new monto TON Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a o nsequence of) Examir physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical e attending ph d for use as th IF FEMALE: 23c. If yes, outcome of pregnancy

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1 ☐ Yes 2 ☐ No Day Pregnant at time of death signed by the a d be detached f 1 ☐ Yes 2 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Noknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Hospital or Attending Physician: The Conar certificate 1 Yes 2 No 25. Was case referred to Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ည 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medi al Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination a new investigation, and set the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature of certi 2010 SwrAtts Road State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 3. Time of Death 255 A 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year / 💍 OLEMAN 0/ /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner MEDICAL L'ENTER ANNAPOLIS ANNE ARUNDA ANNE TRUNDEL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Min. Days 715-03-2079 M 2□ F Director NY 87 8/15/1922 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at MD Edgewater Anne Arundel Director 1 ☐ Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1605 Chesapeake Drive 21037 USA Funeral filed within 72 hours after death of Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?

MRYes 2 | No 43If Yes, Give Year or Dates: 73 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Never Married ★★ Married Baltimore, Maryland 21215-0036 1 ☐ Yes ANO White ð Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumatic event, the once. **CW04 USN 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence Coleman Reina Pope ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Patricia Coleman</u> Wife 1605 Chesapeake Drive Edgewater ,MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/5/2010 | Crownsville, MD Maryland Veterans Cem 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter In Triple Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 ☐ Other (specify) signed by the a d be detached f 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 2 No Division of Vital 1 □ Yes 1 🗆 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one. 29b. Signature au d title of certifier 29c. License number 29d. Date signed (Month, Day, Year) YSICIAN 20051024 01.31.10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Horopolis. 2001 Midia Omen

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State

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31. Date filed (Month, Day, Year)

FEB 02

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month RENE 1130 M 26 10 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner GINGER COVE HEALTH CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🗷 F Yrs. 92 Director 155-01-5763 JUNE 16. 1917 WISCONSIN Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County s 23a or 28a-f show 1 TYes 2X No Director MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4000 RIVER CRESCENT DRIVE 21401 UNITED STATES Pages 1 and 2 should be filed within 72 hours after death unent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status r than "natural", or items the Wedical Examiner Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: δ Specify: WHITE 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 27 is marked other than "r traumatic event Elementary/Secondary (0-12) College (1-4or 5+) **2** HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ CHARLES CRAWFORD LORA WINDSOR 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tronce. 69 McPHERSON ROAD, ANNAPOLIS, MARYLAND 21401 LAURENT DESCHAMPS/SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION JANUARY 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM CREMATION AND FUNERAL CARE, P.A., 814 BESTGATE ROAD, ANNAPOLIS, MARYLAND 21401 4 ☐ Donation 5 ☐ Other (Specify) CENTER 21. Signature of Funeral Service Will Expor 7M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** low disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Z No Month Day Year 5 ☐ Other (specify) P.0. ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□No 1 □Yes 2 No 1 ☐ Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) GINGET Hospital: 1□Yes 2☑No Other: this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 2 ☐ Accident Injury 5 Pending nours after death. neral Director: Af illed in by the fur 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hor To the Fune completely fi Medical (Check only 29b. Signature and title of certifier, 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) DEFENSE HOHWAY ANNAPOLISM OZIEd MICHAEL w 445 ENTA i

DHMH 17 Rev 1/2001

State Registrar 29

31. Date filed (Mont)

Registrar's Signature

32

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Office Enzageti		1- For State	tate of Ivial yi	•	rtificate of		ilia ivie	illai i iy	gierie	Reg. No.	20	10	0419
Physicia	an/	Registrar 1. Decedent's Name (First, Mid	dle,Last)	_					2. Date of D		Year		3. Time of Death
Medical Exami	ner	Shirley		·		Dou	glas		January	26, 20	10		1957 hrs
		4a. Facility Name (if not institut 9450 Jay Street	ion, give street and n	umber)	4	b. City, Town, Waldorf	or Location	n of Death			c. County o Charles	Death	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Y	'ear If Un	nder 24Hrs.	8. Date of	Birth(MM/	(DD/YYYY)		place (State or
Director	**	216-80-1348	1 M 2 F	48	Yrs.	Months D	ays Hou	urs Min.	11/	9/19	61	Foreign Cou	^{ntry} Marylar
	U	Usual Residence of Decedent					I		/	27.12			
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s after ral",	by F		ivorced If Yes, Give Ye or Dates:			Yes 2 🔭					Specify:	Bla	
2 hour		 Decedent's Education (Sp Elementary/Secondary (0-12 		1-4 or 5+)	16a. Decedent during mo	s Usual Occu st of working				16b. k	Kind of Bus	iness/In	dustry
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5-0036 iled within 7 Hygiene. I other than	ပ	17. Father's Name (First, Middle	e, Last)					er's Name (First, Middle	e, Maiden	Surname)		
2121 ould be fi Mental I marked	o Be	James 19a. Informant's Name/Relation	V.	F	armer	Address (St		ry B.				0	7: 0 1)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Integration: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	ř	Francis Doug		band	9450	•					•		
e, K Land 2 Health item 2		20a. Method of Disposition		20b.	Place of Disposit	ion (Name of			Date		Location -		
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Baltimore, permit. Pages I an Department of He Important: If ite		21. Signature of Juneral Service		1_0	t. Cat	me and Addr	ess of Faci	lity	E/_ZUT	Office	COIIC	,,,,,	7,110
	> /	Llax	8	191	Ad	ams F	uner	al Ho	mePa	, Aqu	asco	MI	
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Examiner		Immediate Cause (Final diseas or condition resulting in death)	e a. <u>Metha</u>	adone in	toxicat	ion						\dashv	Death
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7)	miner	if any, leading to immediate cause. Enter Underlying Cause	,	a consequence o	of):								
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal - transit		TY LINDENDED	d. AMENDED.	23a.per	me. 2937	3-28-	-13 sn	n					
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Box 68760, c death certificate by the attending physic ed for use as the bur	an/N	23b. Was decedent pregnant in past 12 months?	the 23c. If yes,	_		al death	3 Ector	pic pregnan	су	230	Month	Da	ay Year
OX (eath ce atth ce attend for use	sici	1 Yes 2 No 9 V Ur		nant at time of de	eath 5 Oth	er (Specify)							
D. B trthe d by the	٩١	Part II. Other significant cond		o death but not r	esulting in the ur	derlying caus	se given in I	Part I.	23e. Did	d tobacco	use contrib	ute to th	ne cause of death?
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/iSiC r Atte fer dea irector	ficat	2 Accident Inve	estigation FQ 1	/26/10 ce of Injury - At h	Fd 7:49 ome, farm, street		e building.	etc. 2	8f. Location	n (Street a	nd Numbe	or Rura	al Route Number, City
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Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the t	calc	100000	Physician: To the be										
To th withir To th	Medical	2 🗸	aminer: On the basis and manner:		ind/or investigate				the time, da				
		29b. Signature and title of certif	1 4111	Δ			ense numbe C.M.E.	-1			uary 27,		th, Day, Year)
		30 Name and address of perso	n who completed care) Ise of death (Item	1 23a)						, ,		
		Pamela E. Southall, I	MD Assistant	Medical Exa	· ·	Penn Stre	eet, Balti	more, MI	21201				
St Regist	ate	31. Date filed (Month Bell)	5 2010 32. B	gistrar's Signati	B. Sa	N. I							
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	1	For State Registrar	State of I	Marylan		artment of H		Mental Hy	giene ,	2010	04200
Physician		Decedent's Name (First, Middle, L. Nham T. Duong	ast)		-			2. Date of Di Month Janua		2010 ^{Year}	3. Time of Death 10:00 a M
Medica Examine	_	4a. Facility Name (if not institution, ga 2108 Fordham Street	ive street and numbe	r)		4b. City, Town, or Hyatts			4c. C	ounty of Death	
Funeral Director		213-04-4173	Sex 1 □ M 2 🖫 F	Age (In yrs. la 92	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		rth ay, Year 1917	9. Birth Cou Viet	pplace (State or Foreign ntry) nam
ryland -f show ied at	. 1	Usual Residence of Decedent 10a. State 10b. County			, Town or Loc						10d. Inside City Limits 1 ☐ Yes 2 🎦 No
ith the Ma 3a or 28a t be notif	=	Maryland 10e. Street and Number 2108 Fordham Stre	P.G. et	H	lyattsvi	10f. Zip Code 2078	3			en of What Cou	
	by Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceder Armed Force: 1 Yes 2	s?	If	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 🛣 No	n, Mexican, Pue	Specify Yes or No to Rican, etc.)		. Race - Ameri Black, White,	
Baltimore, Maryland 21213-5-UU36 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam	Completed	3 🙀 Widowed 4 🗆 Divorced 15. Decedent's (Specify only highest	Year or Dates Education grade completed)		16a. Deced	ent's Usual Occupa	ation	orking		As: I of Business Ir	ian ndustry
IC 212	a B	Elementary/Seconday (0-12) 17. Father's Name (First, Middle, Las	College (1-4 o	or 5+)		memaker	18. Mother's Na	ame (First, Middle		n Home	
arylan lould be fi nd Mental marked marked	<u>ا</u>	Thuy Duong 19a. Informant's Name/Relationship	(Type, Print)		19h Mailin	g Address (Street a	Thin Nguy	en			Code)
ore, Maryland 1 and 2 should be file of Health and Mental I fitem 27 is marked or		Doan T. Nguyen/Daug		20b. P	7000 :	20th Avenue	, Hyattsv		20783	ation - City or T	
Baltimory permit. Page 1: Department of I Important: If it any injury or of		1 ☐ Burial 2 🕱 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lice	cify)		opolita	n Crematory	12	b. 3, 010	Alexar	ndria, V	irginia
Departing any ir.		23a. Part 1. Enter the disease, or co	Deley	and the death		Name and Addres				ng, MD 20	
Physician Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each Dementia a.	line.	i. Do not ente	The mode of dying	, such as cardia	o or respiratory a	nest,		Approximate Interval Between Onset and Death
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcon 1 ☐ Live Birt 4 ☐ Pregnan 9 ☐ Unknow	h 2 ☐ Feta It at time of d	Ideath 3	Ectopic pregnancy Other (specify)	′		23	d. Date of deliv	very Day Year
S, F.C. res that the signed by a be detacl	à	Part II. Other significant conditions Bladder Cancer	contributing to deat	h but not resu	ulting in the u	nderlying cause give	en in Part I.				he cause of death?
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JIVISION al or Attendii s after death. I Director: At	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of	Injury - At horetc. (Specify)		et, factory, office			Street and N wn, State)	lumber or Rura	l Route Number,
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vithi To th		29b, Signature and title of certifier	1/2	MD		29c. License	number 4486			signed (Month,	Day, Year)
		30. Name and address of person who	•			rint)		, MD 20912	2		
State Registra		FEB 0 3 201	1.7								

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 01 **Physician** 20°10 38 6:30A M Roger Coit Dixon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Mitchellville Collington Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/13/1914 5. Social Security Number 6. Sex 1**X** M 2□ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours New Hampshire 95 Director 579 34 1563 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 14 Yes 2□ No MD Prince George's Mitchellville Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20721 United States 10450 Lottsford Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int; If Item 27 is marked other than US Foreign Service Officer Department of State 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Tucker Frank Haight Dixon 2 permit. Pages 1 and 2 should Department of Health and Me Important; If Item 27 is mark any injury or other traumati once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 06074 58 Windshire Drive South Windsor, CT Peter Thomas Strong/Step-Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/02/2010 Falls Church, VA National Crematory 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 21. Signature of Funeral Service Licenses 5130 Wisconsin Ave., NW Washington, DC Whit ///WM8 23a. Part1. Enter the diseas, or complications to taused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Week Immediate Cause (Final disease or condition resulting in death) Intracerebral Hemorrhage **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): executed and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Hospital or Attending Physician; The law requires that the death certificate be Physician/Medical as asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 □Yes 2 □ No detached 9 Unknown 9 \square Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Atrial Fibrillation 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy performed certificate 1 □ Yes 2 No 1 ☐Yes 2 ☐ No 24 hours after death.

Funeral Director: After this certific letely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ∏Yes 2√∑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) completely and manner stated. within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 D47603 02/01/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William F. DuBoyce MD 12158 Central Ave. Mitchellville, MD 20721 31. Date filed (Month, Day, Year) 3. Registrar's Signature State FEB 03 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Jan 26,2010 9:45am Gilbert Bryan Devey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Chevy Chase Brighton Gardens If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, **Funeral** Hours Months Days 1**X** M 2□ F Jan •05,1921 Director 89 Pennsylvania 162-14-8599 Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 🔀 No Director MD Montgomery Chevy Chase 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5555 Friendship Blvd. Apt. 521 20815 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2☐ No 1938— IfYes, Give Year or Dates: 1944 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 21 No Specify: White þ 3 ₩ Widowed 4 Divorced 1944 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry National Elementary/Secondary (0-12) College (1-4or 5+) Technology Consultant Science Foundation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel George Devey Marjorie Graham ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1508 Haas Court Davidsonville, MD 21035 Gilbert B. Devey Jr. / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 01/30/2010 Falls Church, VA 5 □Other (Specify) National Crematory 4 Donation 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the ise se, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Years **Physician** Prostate Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Years Coronary Artery Disease Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Years attending physician and for use as the burial-transit Hypertension Due to (or as a consequence of): Box 68760, pe Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 ☐ Other (specify) ☐Yes 2☐No P.0. ed by the detached f 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Atrial Fibrillation Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s performed? 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Assiste director, 26. Place of Death (Check only one) Be Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \cancel{R}$ Other (Specify) Living 1 ∐ Yes 2 🗗 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 1 Natural 5 Pending e Hospital or Attendin 124 hours after death. e Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medica (Check only one) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature e of certifier D33844 1/26/2010 ddress of person who completed cause of death (Item 23a) (Type, Print) 30. Name an Vassallo MD 5454 Wisconsin Ave. Chevy Chase, MD 20815 Joseph FEB 0 0 1 2010 31. Date filed (Month, Registrar's Signature parke Registrar

DHMH 17 Rev 1/2001

			Please	Type or Print in E							
			For State Registrar	State of Marylan		artment of H <i>rtificate of L</i>			'giene Reg. No.	ZUIU	04203
i	Physicia /Medic		1. Decedent's Name (First, Middle, La	M. De-	TOUR			2. Date of De Month	Day 2	4 2010	3. Time of Death
	Examin		4a. Facility Name (<i>If not institution, giv</i> Shady Grove Adve			4b. City, Town, or Rockvill	Location of Death			County of Death Montgomer	у
	Funeral Director		5. Social Security Number 6. S 104-26-7793	ex	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Do May 7,	rth ay, Year) 193	Country	ce (State or Foreign y) ork
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince G		y, Town or Lo er Mar					10d	I. Inside City Limits 1 □ Yes 2 ♣ No
	with the	J Direc	10e. Street and Number 5608 Havenwood Co	urt		10f. Zip Code 20772				tizen of What Country ted State	
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, tre mortical Evanian must be notified a	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ⊠ No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	0-	14. Race - Americar Black, White, etc	·.
Maryland 21215-0036	han "natura han "natura Modical E	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give life. i	DO NOT use retired	during most of work	ing	16b. K		
1d 21	e filed wall Hygier other tl	Be Co	12 17. Father's Name (First, Middle, Last)	Hom	emaker	18. Mother's Name		e, Maiden	Own Ho	
rylar	permit. Fages 1 and 2 should be filed within 7.2 thours after death with the Mat year I mortant of Health and Mental Hygiene. Important: If them Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its marked to the process. 2006.	To E	James Harper 19a. Informant's Name/Relationship	(Type Print)	19b. Mailir	ng Address (Street	Alberta and Number or Rur		ber, City o	or Town, State, Zip C	Code)
, Ma			Arden J. DeFour	(Spouse)	5608	Havenwoo	d Court,	Upper	Mar1	boro, MD	20772
altimore,	Pages 1 lent of H nt: If ite ry or otl		20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci.	Removal from State Δ 1	emetery, crer	sition (Name of matory or other place s Cemeter	e) Febri	uary 1,		mantown,	
Balti	permit. Departm Importa any inju		21. Signature of Funeral		1	2. Name and Addres	ss of Facility De	Vol Fun	eral		
	Physician /Medical Examiner		23a Part 1 Enter the disease, or comshoot. Wheart failure. List only Imme in a Cause (Final disease or condition resulting in death)	pplications that caused the deat one cause in each line. a	MY	er the mode of dyin	ng, such as cardiac	or resultatory	arrest,	1	Approximate nterval Between Onset and Death
	te be executed ysician and e burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b							
P.O. Box 687	Physician: The law requires that the death certificate this certificate has been signed by the attending physical director, page 2 should be detached for use as the training the control of the control	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3[☐ Ectopic pregnanc ☐ Other (specify) _	÷y			23d. Date of deliver Month	y Day Year
rds, P.	quires that the de in signed by the a uld be detached f	ρ	Part II. Other significant conditions	contributing to death but not res	culting in the u	nderlying cause giv	ren in Part I.		tobacco]Yes 2	use contribute to the	e cause of death?
Vital Records,	: The law requir cate has been s page 2 should I	Completed	V					24a. Wa aut per 1 □ Yes	opsy formed?	prior to com death?	sy findings available pletion of cause of 2 No
Vita	ilcian: Th certificate ector, pag	æ	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Dear				
J Of	ding Physician:). After this certific funeral director,	n: To	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	ER/Outpatie 28b. Time o Injury	nt 3 🗆 DOA	4 Li Nursing H	ome 5 ☐ Res 28d. Describe		6 ☐ Other (Specify, ury occurred)
Division of		Certification: To	2 Accident investigatic 3 Suicide 6 Could not 4 Homicide	De 28a Place of Injury - At h	ome, farm, st]Yes 2 □ No	28f. Location City or To	(Street a	and Number or Rural te)	Route Number,
	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, dea ation and/or i	th occurred at the ti nvestigation, in my	ime, date and place opinion, death occu	e, and due to the	ne cause(e, date ar	s) and manner as stand place, and due to	ated. the cause(s)
_	To the within to the comple	Me	29b. Signature and title of certifier	()	17	29c. Licens			29d. D.	ate signed (Month, E	Day, Year)
_		-	_ / 2 .						1 / /		

30. Name and address of person who completed cause of death (Item 23a) (Type, P (a) Cente Dr Rockerthe My 90 0

State Registrar 31. Date filed (Month, Day, Year)

JAN 2 9 2010

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 2010 Barrington Drew 2:00 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday **Funeral** 1 🖾 M 2 🗆 F June 30 1933 Pennsylvania 180-28-5152 76 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 28a-f 1 Yes 2 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? ច with 23a Funeral 3221 Regina Drive 20906 IISA items ? 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status ō þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 Specify: White 1 ☐ Yes 2 K No Specify: "natural", X Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Aeronautical Engineer Government Contractor Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harry Drew Marion Doherty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Ann Kearney/Daughter 4901 Short Drive, Mount Airy, MD 21771 f Health item 27 other tra Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2x Cremation 3 Removal from State Jan. 2010 28 Metropolitan Crematory injury 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spr Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chrcnic Obstructive Pulmonary Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after cleath.
 Funeral Director. After this certificate has been signed by the attending physician and red filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Renal Insufficiency, Diabetes Mellitus, Type II Division of Vital Records, 1 Tes 2 No 3 Probably 4 😾 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 2 No Inpatient 2 ER/Outpatient 3 DOA ဂ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 5 \square Pending 1 Natural Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours aft

To the Funeral Di

completed filled in Medical 1 XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) ٩ D32332 January 26, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Suresh K. Gupta, MD 9801 Georgia Avenue, #220, Silver Spring, MD 20902

State Registrar 31. Date filed (Month, Day, Year) JAN 2 9 2010

32. Registrar's Signature

			For State of Marylan	id / Depa	artment of Hea	alth and M	fental Hyg	iene	10	042	05
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of Dea	ath	2. Date of Deat	eg. No.	, 0		
	Physicia	n/						" 31/2010	Year	3. Time of 9:40	A M
	Medic Examin		Margaret Ann Douglas 4a. Facility Name (if not institution, give street and number)		4b, City, Town, or Loc	cation of Death	1/	4c, County		7.40	A
, 1	£		4010 Nicholson Street		Hyattsvi]	l1e		Princ	e Ge	orge's	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. I			Under 24 Hrs. lours Min.	8. Date of Birth	.Year)	9. Birth Cour	place (State or	Foreign
	Director		579-34-0445 1 81 Usual Residence of Decedent	Yrs.			(Month, Day, 7/23/	1928		son, M	
	10a. State 10b. County 10c. City, Town or Location							T	10d. Inside Cit	y Limits	
	Maryla 28a-f	Director	MD Prince George's Hyan	ttsvill	Le					1 X Yes	2 🗆 No
	a or 2	<u>=</u>	10e. Street and Number		10f. Zip Code		1	10g, Citizen of	What Cou	ntry?	
	th with ms 23 must	Funeral	4010 Nicholson Street	- La v	20782	1 0 1 1 0 10	" V N		U.S		
10	r dear		11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.s Armed Forces? 1 □ Yes 2 ☒ No	S. 13. V	Vas Decedent of Hispa f Yes, specify Cuban, N	inic Origin? (Spe Mexican, Puerto	Rican, etc.)		e - Americk, White,	can Indian, etc.	
036	s afte ral", c Exan	Completed by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1	Yes 2 No S	Specify:		Specify	· W	hite	
5-0	2 hour "natu dical	plet	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupation	n na most of worki	ina	16b. Kind of B	usiness In	idustry	1
121	thin 73	Ĕ	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DO	O NOT use retired)			n c c-		D., b 1 4 .	Coboo
15 Q	ed with Hygie other sint, the	l or l	12 17. Father's Name (First. Middle, Last)	Caret	eria worke		e (First, Middle, N	P.G. Co		Public	e School
laŭ	be fill ental rked c	[후	George T. Stone, Sr.			largaret			-/		
ary	hould and M s mar	П	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and			City or Town,	State, Zip	Code)	
Σ	nd 2 sealth an 27 i		David L. Douglas / Son	10307	Balsamwoo	od Drive	, Laure	1, MD	2070	8	
Baltimore, Maryland 21215-0036	roft, fiter or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	Place of Dispos cemetery, crem	sition (Name of natory or other place)	1	Date	20c. Location	- City or T	own, State	
ţ	t. Pag tmeni rtant: njury		4 □ Donation 5 □ Other (Specify) Ga		Heaven Ceme			Silver			
Bal	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee		Name and Address o			4739 Ba Hyattsv			
			23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.	th. Do not ente	er the mode of dying, s	uch as cardiac o	or respiratory arre	est,		Approximate Interval Bet	ween
J	Physician/		Immediate Cause (Final disease or condition	Cana	25				- 1	Onset and D	Death
-	Medical Examiner		resulting in death) Due to (or as Ronseq	uence of):							
		je.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conseq	uence of):					-		
	rted d ansit	Examiner	cause, Enter Underlying Cause (Disease or linjury						-		
	cate be executed physician and s the burial-transit	Ě	that initiated events resulting in death) Last C. Due to (or as a conseq	uence of):							
09	ite be hysicii he bu	dical	d								
387	rtifica ling pl	/Me	IF FEMALE: 23c. If yes, outcome of pregna	ancy							
Box 687	death certificate be executed ne attending physician and ed for use as the burial-transi	Physician/Me	in the past 12 months?	al death 3	Ectopic pregnancy Other (specify)				ate of deliv onth	•	/ear
W		hysi	1 Yes 2 No 4 Pregnant at time of 9 Unknown								
P.O.	that the ned bedeta	by P	Part II. Other significant conditions contributing to death but not res	sulting in the u	nderlying cause given	in Part I.	23e. Did tol	bacco use con	tribute to t	he cause of d	eath?
ds,	quires en sig ould b	ted					1 🗆 Y	es 2 No	3 🗌 Pro	bably 4 🔼 I	Jnknown
cor	SE S	Completed					24a. Was a autops	sy		opsy findings a ompletion of c	
Re	: The la icate har r, page	Sol					perform 1 Yes			2 🗌 No	
/ital	sician certif irecto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Hospital: 1 Inpatient 2	150/0-4-4	045-044	of Death (Checi	k only one) ome 5 X Reside	<u></u>	<i>(</i> 0 : <i>(</i>	- 3	
of \	g Phy er this eral d	e: To	27. Manner of Death 28a. Date of injury	28b. Time of	28c. Injury at		28d. Describe ho			<u>y)</u>	
ono	anding sath. or: Afte he fun	ficat	2 Accident Investigation	injury	M 1 ☐ Yes	s 2 🗆 No					
Division of Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completed filled in by the funeral director, pag	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At h building, etc. (Specif	ome, farm, stre ý)	eet, factory, office		28f. Location (St City or Town		er or Rura	al Route Numb	er,
Ö	ours a		29a. Certifier 1 Exertifying Physician: To the best of my know	vledge, death (occured at the time, da	ate and place, ar	nd due to the cau	se(s) and manr	ner as stat	ed.	
	To the Hospital or A within 24 hours after To the Funeral Direct completed filled in b	Medical	(Check 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practioner: To the best of m	on and/or invest	tigation, in my opinion, o	death occurred a	t the time, date an	id place, and du	ie to the ca	ause(s) and ma	nner stated.
	To the composite of the	_	29b. Signature and title of certifier		29c. License nu	mber	2	29d. Date signe	d (Month,	Day, Year)	
			Jose Menthy		1201	453		02/	02/	2010	•
1	210		30. Name and address of person the completed cause of death (Iter Jose Luis Mendoza, 8626 Woodya	m 23a) (Type, P		. MD 20	735				
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Sign		a, OTTHEUH	, III 20	, ,,,	-			
	Registr		31. Date filed (Month, Day, Year) 32. Registrar's Sign	TITE -							

			For State Registrar	tate of Maryland /	•	artment of tificate of			Reg. No.	10	04206
	Physici /Medic Examir	al	Decedent's Name (First, Middle, Last) Tyrone P 4a. Facility Name (If not institution, give street 2104 Weber Dr		Sr	4b. City, Town,	or Location of Dea		- 2019 4c. County		3. Time of Death 12:22PM eorgé's
	Funeral Director		5. Social Security Number 6. Sex 1 № M	2□ F 7. Age (In yrs. last to 62	birthday) Yrs.	If Under 1 Year Months Days			1947 1947	9. Birthp Coun Wash	lace (State or Foreign ltry) lington DC
	r 28e-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County Md Prince Ge	orge's For		cation ville				1	0d. Inside City Limits 1 🛣 es 2 🗆 No
	death with the Maryland rms 23a or 28e-f ehow frount be notified at	Funeral Director	10e. Street and Number 2104 Weber Dr		40.1	10f. Zip Code 20747	Life and Original (10g. Citizen of USA		
9036	ours after de rai', or item	by	1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces? 1965 Axes 2□No 1Yes, Give 1967 Year or Dates:		Nas Decedent of f Yes, specify Cu I ☐ Yes 2 🛣 No		Specify Yes or No rto Rican, etc.)		ck, White, by: Bla	etc.
Maryland 21215-0036	2 should be filed within 72 hours after and Mental Hygiene 1e marked other than "natural", or ite raumatic event, the Madical Exemina	Completed	15. Decedent's Education (Specify only highest grade contents (Secondary (0-12)		(Give	DO NOT use retir	during most of w	orking	16b. Kind of B		
yland		To Be C	17. Father's Name (First, Middle, Last) Lindsey W Dodson					ame (First, Middle V Squa		me)	
	es 1 and 2 should b of Heelth and Ment I Item 27 is marked r other traumatic e		19a. Informant's Name/Relationship (Type, Tyrone Dodson Jr	1				Rural Route Numb Upper			Code) 1d 20774
Baltimore,	Pages 1 ar ment of Hee tant: If item? jury or other		20a. Method of Disposition 1 ⊠Burial 2 ☑ Oyernation 3 ☐ Remo 1 ☐ Donation 5 ☐ Othey (Specify)	20b. Place	of Dispo tery, cree tank	sition (Name of natory or other pl Iam Cem	etery ² -	1 ^D 0 ^{te} -201) ^{20c. Location} Chelta	- City or To anhan	own, State
Balt	permit. Pag Department Important: I any injury o		21. Signature of un eral Service Licensee	4							Funeral Plains Md
	Physician /Medical		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one collises of condition resulting in death) a	ause on each line.	R	- 0		ac or respiratory a		2	Approximate Interval Between Onset and Death
760,	te be executed axe by sicien and and are burlat-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence	e of):						
P.O. Box 68	ne death certifica the ettending ph thed for use as th	by Physician/Medi	in the past 12 months?	f yes, outcome of pregnancy 1⊡Live birth 2∏ Fetal dea 4∏ Pregnant at time of death 9⊟ Unknown		Ectopic pregnan	су			ate of delive	ery Day Year
	quires that the signed by the detaction of the detaction of the detaction of the detaction of the sign	ed by Ph	Part II. Other significant conditions contrib	· ·	j in the u	nderlying cause g	iven in Part I.		obacco use con Yes 2 □ No	ntribute to th	ne cause of death?
Vital Records,	n: The law requ licate has been r, page 2 shoul	Completed						24a. Was auto perfo 1 Yes	rmed?	death?	psy findings available mpletion of cause of
Vita	ysicien: is certific director	To Be	25. Was case referred to medical examiner? 1 XYes 2 No	ital: 1 ☐ Inpatient 2 ☐ ER/	Outpatier	t 3□ DOA O		eath <i>(Check only c</i> Home 5 XResi		her (Specif	y)
Division of	ing Ph kter thi ineral	Certification; T	2 Accident investigation	8a. Date of Injury (Month, Day Year) 8e. Place of Injury - At home, building, etc. (Specify)	injury	28c. Inj W M 1[ury at ork? ∐Yes 2 □ No	28d. Describe	how injury occur	rred	ti Route Number,
ā	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi		29a. Certifier 1 ☐ Certifying Physicia	in: To the best of my knowled	ige, deati	occurred at the	time, date and place	ce, and due to the	cause(s) and m	anner as s	tated.
	To the Ho within 24 I To the Fu completel	Medical	(Check only one) 2 Medical Examiner: 29b. Signature and title of certifier	On the basis of examination and manner stated.	and/or in	One Lines	an aumber		20d Date signs	nd /Month	Day Your)
	F \$ F 8		An Grada	Sporto	00	140	0055	927	Febr	uan	, 3, 2010
2	10+1		30. Name and address of person who composite of the state	e cause of death (Item 23:	a) (Type,	Print) Hospi	tal D	927 ine	Cleve	S.	hosford
	Sta Registi		FEB 0 4 2010	we B. A	als	/					,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DAWSON 6.25AM JOYCE Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AMME UHDE MEXICAL WACHINGTON BARTER CLEN If Under 1 Year 8. Date of Birth (Month, Day, Ye Apr. 8 6. Sex Age (In yrs. last birthday) If Under 24 Hrs. g. Birthplace (State or Foreign **Funeral** 1 □ M 2**XX** Months Davs Hours Min. 238-64-0185 66 Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Bowie 1X Yes 2 ☐ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20716 USA 16121 Edenwood Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Bace - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married þ 1 Yes : 2 XNo African Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Willie Lee Hamilton Nina Mae Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharonetta M. Sloan /daughter 16121 Edenwood Dr. Bowie, MD 20716 Important; If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2/2/2010 Elmwood Cemetery Goldsboro, NC 21. Signature of Juneral Service Licenses 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, 20715 23a. Part 1. Enter the disease or compli¢ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate only one cause on each line Interval Between Onset and Death shock, or heart failure. Lis Immediate Cause (Final Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate
Cause (Disease or iinjury to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical ANDYO Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) the detached □ Unknown g Unknown as been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an certificate has completed filled in by the funeral director, page 2 autopsy prior to completion of cause of death? 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA After this 27. Mannyr of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Natural death. ☐ Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 | only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 200

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100

#10

130,00

31. Date filed (Month, Day, Yea

10-00819	
Blake Dotson	

lake Dotson	State of Maryland / Department of the State of the State of the		lygiene 201	0 0420			
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year	3. Time of Death			
Medical Examine	Blake Duane Dotson 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	January 28, 2010 h 4c. County of De	1919 hrs			
	Washington County Hospital	Hagerstown	Washington				
Funeral Director	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	If Under 1 Year If Under 24Hrs Months Days Hours Min	s. 8. Date of Birth (MM/DO/YYYY) 9. April 28,1954 For	Birthplace (State or eign Maryland Country)			
á	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits			
Maryland 28a-f show any datonce. ector	Maryland Washington County Hagerstow	'n		1 X Yes 2 No			
the Maryland or 28a-f sh iffied at once	10e. Street and Number	10f. Zip Code	10g. Citizen of What Co	ountry?			
ith the 1 23a or notifie		21740 Vas Decedent of Hispanic Origin? (S)	U.S.A.	erican Indian, Black,			
or items 23a or 28a-f sho must be notified at once. Funeral Director		Yes, specify Cuban, Mexican, Puerto	o Rican, etc.) White, etc				
	3 Widowed 4 Divorced If Yes, Give 9-43-1975 1	Yes 2 No specify:	Specify.	hite 			
136 hin 72 hours after e. e. e. e. edical Examiner	work done 16b. Kind of Busines tired)	s/Industry					
5-0036 ed within 72 hour other than "natu ine Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Jani	tor	Cleaning	Company			
	17. Father's Name (First, Middle, Last) Kenneth Dotson						
2121 could be fill d Mental H s marked tic event,			Rural Route Number, City or Town, Sta	ate, Zip Code)			
MD and 2 shoulth and m 27 is aumatic	Pameland. Dotson-wife 116 B	Cast Ave. Hagerst		- O			
Ore,	1 Rurial 2 X Cramation 3 Removal from State crematory or	osition (Name of cemetery, other place) rg Crematory 2-3	Date 20c. Location - City Smithsbur	g, Maryland			
altimore, mit. Pages I ar partment of Hee portant: If ite	4 Donation 5 Other Specify:	0	ouglas A. Fiery Fu				
Balti permit. Departr Imports injury o	Kritlin Zalfaron Seiter 1	331 Eastern Blvd.	. North Hagerstown				
Physician /Medical	23a. Part I. Enter the disease for complications that caused the death. Do not enter failure. List only one cause on each line.			Approximate Interval Between Onset and Death			
Examiner	Immediate Cause (Final disease or condition resulting in death) a Atheroslerotice card Due to (or as a consequence of):	iovascular diseas	se	Death			
_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):						
mine mine	if any, leading to immediate cause. Enter Undanying Cause (Disease or injury that initiated						
d d ansit	events resulting in death) Last Due to (or as a consequence of): d.						
to, e be executed systian and burial - transit	☑ UNPENDED ☐ AMENDED 23a.27.permE.	. g900 2/22/10 TT		N A			
3760, ficate be g physic s the burn		etal death 3 Ectopic pregna	23d. Date of deliv	ery Day Year			
b. Box 6876(the death certificate by the attending phys ched for use as the b Physician/Me	past 12 months? 1	Other (Specify)					
□	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?			
, P.O.			1 Yes 2 No 3 P	robably 4 Unknown			
cords law requi			autopsy prior t	autopsy findings available o completion of cause of			
tal Records, ian: The law require certificate has been signer, page 2 should b. Be Completed			performed? death 1 ✓ Yes 2 No 1 ✓				
fital sician: is certifirector,	25. Was case referred to medical examiner?	26.Place of Death (Check	only one) ing Home 5 Residence 6 Ot	her:			
ing Phys After this funeral di	27 Manner of Death 28a Date of Injury 28b Time of		28d. Describe how injury occurred				
IVISION or Attendianter death. Director: /	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No		D. I.D. I. N. other Oil			
Division of Vital Records, spital or Attending Physician: The law requirmours after death. neral Director: After this certificate has been sir filled in by the funeral director, page 2 should be Certification: To Be Completed	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, structure (Specify)	eet, factory, oπice building, etc.	28f. Location (Street and Number or or Town, State)	Rural Route Number, City			
y fill							
To the How within 24 h To the Fur completely	one) 2 Medical Examiner: On the basis of examination and/or investige and manner stated. 29b. Sugnature and take of certifier	ation, in my opinion, death occurred	at the time, date and place, and due to				
	29b. Signature and title of certifier	O.C.M.E.	January 29, 20				
	30. Name and address of person who completed cause of death (Item 23a)						
		Penn Street, Baltimore, MD	21201	 			
State	31. Date filed (Month, Day, Year) 32. R/gistrar's Signature	a shall					

DHMH 17 Rev 1/2001 OCME 2006

OCME

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** January 21, 2010 5:15 PM Gilbert Echt /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville 8. Date of Birth (Month, Day, May 21, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Hours Min. 1925 1⊠M 2□ F Months Days Ohio 284-18-3965 Director 84 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State show other traumatic event, the Medical Examinar Lust be notified at Gaithersburg Maryland Montgomery 1 ☐ Yes 2X No Director 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States items 23a 419 Russell Avenue, Apt 113 20877 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Black, White, etc 72 hours after 1 Mayes 2 No Worl If Yes, Give Year or Dates: War II 2□No World 1 Never Married 2 x Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 TXT No Specify Specify: 2 3 Widowed 4 Divorced White "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Military and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Contractor Aerosp**a**ce Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe Anna Sheon Harry Echt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ${
m Apt.} \ 113$ permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once. 419 Russell Avenue, Gaithersburg, MD 20877 Joyce Echt (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition January 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Metropolitan Crematory 4 Donation 5 Dother (Specify) 2010 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 wites 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a managuence of) Examiner Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transil Exami resulting in death) Last Due to (or as a consequence of Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal deat 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No o 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this : After thi 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide hours after within 24 hours a

To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c License number 29d. Date signed (Month, Day, Year) 29b. Signature an D0057574 110 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ahmed Y. Heshmat, M.D. 10110 Molecular Drive, Suite 200, Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Genia EISENFELD 20TO 23 8:15 P January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hebrew Home of Greater Washington Montgomery Rockville . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Days (Month, Day, Year) Sept. 5 Months Hours Poland **Director** 112-26-1904 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring Montgomery Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20902 United States 10 Yeatman Court filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: white "natural", 3 TWidowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'any injury or other traumatic excess. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Chana (unknown) Chaim Lenz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20902 10 Yeatman Court, Silver Spring, MD Michele Reitberger, Stepdaughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ner Tamid Cemetery 01/27/10 4 Donation 5 Other (Specify) Rosedale, MD 21. Signature of Funeral Service Licensee 1008 ²² Name and Address of Facility Torchinsky Hebrew Funeral Home Carroll St NW Washington DC 20012 23a. Part 1 Epper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown detached for Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe Division of Vital Records, 1 Tes 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 2 100 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Sign 29c. License number 29d. Date signed (Month. Day, Year)

State

Registrar

2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ZUIU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 10:55 AM Richard W. Enders January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Montgomery 106 Booth Street #14 Gaithersburg Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** (Month, Day, Year, July 11, 1 🗙 M 2 🗆 F Months Days Hours Min. **Director** <u>Penńsylvania</u> 717–12–3068 94 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 106 Booth Street #14 20878 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🙀 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ntal Hygiene. ced other than " event, the Mer Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Director of Research & Planning Retail Corporation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F 9 Warren Winfield Enders Kinter Charles Carrie other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Enders/daughter 131 Elmira Lane Gaithersburg, Maryland 20878 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If its any injury or ot 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 1/27/2010 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland permit. 21. Sign were of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD Thomas M00957 MD23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Acute Leukemia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying sician and burial-transit Exami Cause (Discase or finjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, Failure to thrive 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 ☐ No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, or Attending Physician: æ 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \bigcirc Residence 6 \square Other (Specify) 1 Yes 2 XNo 읻 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Natural 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the l within 2 To the l only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) D0062435 January 26, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sayed Elsayyad 10110 Molecular Drive Rockville, Maryland 20850 32. Registrar's Signature State

Registrar

- ERRAL

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 1:03 A M 01/24/2010 MARVIN R. EASON /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8404 Woodland Manor Drive Anne Arundel Laurel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours **№** M 2□ F OM Director 66 09/01/1943 500-44-4890 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at Anne Arundel 1 ☐ Yes 2 No Director MD Laurel 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number filed within 72 hours after death with USA 8404 Woodland Manor Drive 20724 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: 2 Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Magny injury or other traumatic event, the Magnes Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland <u>Civil Rights Manager</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Booth John Eason ం 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8404 Woodland Manor Drive, Laurel, MD 20724 Carol Eason - wife Baltimore, 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/29/10 Arden't Crematory Hanover, MD 22. Name and Address of Facility Snowden Funeral Home 21. Signatur of Funeral Service Licen . 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease or complications that caused the death shock, or heart failure. It is only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) - Physician months Pancreatic cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Entire of cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of) law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. the 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Jaundice icate has been się ; page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 □Yes 2 No 1 ☐Yes 2 ☐No Division of Vital Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral of 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation ithin 24 hours after death.

the Funeral Director: A

mpletely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10 01/26/2010 D28998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cherry Lane, Suite 211, Laurel, MD 20708 9101 Pritam S. Saini 31. Date filed (Month, Day, Year) 32 Registrar's Signate State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Paris Solomon Essoumba

2010 04213

		- For State	Ce	rtificate of	Death		Re	g. No.	
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)				Date of Death Month	Day Year	3. Time of Death
ાંcal Exami	ner	Paris Solom	on Tali Essou	mba			February 1	, 2010	1912 hrs
		4a. Facility Name (if not institution, give	street and number)	4	b. City, Town, or Lo	ocation of Death		4c. County of	
		55 Kinsman View Circl	Le		Silver Spring			Montgome	
Funeral		Social Security Number 6. S	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24Hrs	-	h(MM/DD/YYYY)	9. Birthplace (State or oreign
Director		214-37-0849	M 2 F 1	7 Yrs.	Months Days	Hours Min.	Aug. 2	7, 1992	Country) DC
	-	Usual Residence of Decedent					10-		
any	ŀ	10a. State 10b. County	10c. City	, Town or Location	on				10d. Inside City Limits
*		Maryland Montgo	merv		Silv	ver Spri	ng		1 X Yes 2 No
Aaryland 28a-f show 1 at once.	횴	10e. Street and Number			10f. Zip Code			g. Citizen of Wha	t Country?
th the Maryland 23a or 28a-f sho notified at once	Director		W4 C41 -		2/	0901		Unito	d States
th th 23a notif		55 Kinsman 11. Marital Status	12. Was Decedent Ever in U	IS 13 Wa	s Decedent of Hisp		pecify Yes or No-		American Indian, Black,
th wi	uneral	1 X Never Married 2 Married	Armed Forces?		es, specify Cuban,			White,	etc.
or dez	리	3 Widowed 4 Divorced	1 Yes 2 X No	1	Yes 2 X No	specify:		Specify:	Black
s after	۵	15. Decedent's Education (Specify of	or Dates:	16a. Deceden	t's Usual Occupation	on (Give kind of v	work done	16b. Kind of Busi	
hou hou	eted	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mo	ost of working life.	DO NOT use reti	red)		
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l with	omple	17. Father's Name (First, Middle, Last))		1	8.Mother's Name	(First, Middle, N	naiden Surname)	
:15 e filec al Hy red o	Be C	Parfait 1	Modeste Essoum	ba			Dorcas	Namasaka	a
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		19a. Informant's Name/Relationship (1		19b. Mailing	Address (Street	and Number or I	Rural Route Num	ber, City or Town,	State, Zip Code)
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygenether 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	_	Dorcas Essoumba	a/ Mother	55 K:	insman Ci	rcle S	ilver Sp	oring, Mo	1. 20901
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mornal Hygens II Important: If item 27 is marked other than "natural", injury or other traumatic event, the <u>Medical Examiner</u>		20a. Method of Disposition		Place of Dispos crematory or oth	ition (Name of cem	netery,	Date	20c. Location - (City or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 X Cremation 3			Crematory	v 2/1	1/2010	Clint	on, Maryland
tim t. Pa tmen rtant y or e		4 Donation 5 Other Specify 1. Signature of Funeral Se ica \ cer	1988		lame and Address				
Bal Depar Impo	1. 1	Signature of Veneral person (CO.	Colfee of	7.822	001 Benn				
	-	23 Famili. Enter the disease, or comp	olications that caused the deat						
Physician Medical		failure. List only one cause on e	ach line.						Death
Examiner		Immediate Cause (Final disease a or condition resulting in death)	Asphyxia Due to (or as a consequence	of):					
		h	Hanging	·					
	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	of):					
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pa asit	Exa	events resulting in death) Last		01).					
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Sox 687 leath certific e attending p	cia	past 12 months?	4 Pregnant at time of		ther (Specify)				
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F Vi Physi rrthis	₽	1 Yes 2 No 27. Manner of Death	28a Date of Injury	28b. Time of	· · · · · ·	ry at Work?		how injury occurre	ed
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Division of Vital Records, tal or Attending Physician: The law requirers after death. To all precents After this certificate has been sight in by the funeral director, page 2 should be to in by the funeral director, page 2 should the tall of tall of tal	Certification:	3 Suicide 6 Could no determin	t be		ot, idoloty, omes a	ananig, etc.	or Town.	State) View, Silver Spr	
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五 4 至 5 百 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	cal	(Check only 1 Certifying Physical one) 2 Medical Examin	cian: To the best of my knowledge: er:On the basis of examination	and/or investiga	ation, in my opinion	n, death occurred	at the time, date	and place, and d	ue to the cause(s)
To the within 2 To the Complet	Medical	29b. Signature and title of certifier	and manner stated		29c. Licens				ed (Month, Day, Year)
	2	200. Signature and the or certifier	(m)		0.C.			February 2	, 2010
		Men Brasil	1/110						
0		30 Name and address of person who	o completed cause of death (It Assistant Medical Exan		Penn Street, E	Baltimore. MI	D 21201		
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		The second secon							

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 25 Flood Norma Harris ZOIU 10348AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Prince George's 4b. City, Town, or Location of Death Examiner Doctors Community Hospital Lanham Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth
(Month, Day, Year)
Dec. 17, 9. Birthplace (State or Foreign Funeral 1 □ M 2 🔀 Director 577-42-0861 78 1931 Virginia Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits Director "natural", or items 23a or 28a-f sl edical Examiner must be notified Prince George's Lanham Maryland 1 ☐ Yes 2 🗶 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 9211 Rolling View Drive 20706 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
item 27 is marked other than "natural", or other traumatic event, the Medical Examir Completed by orma 1 ☐ Yes 2 🙀 No Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Maryland 2121 U. S. Coast College (1-4 or 5+) Elementary/Seconday (0-12) Personnel Specalist Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Benjamin Harris Nannie Baber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard S. Flood, Jr./Son 4116 Woodrow Lane, Bowie, Maryland 20715 Page 1 and 2 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Maryland Veterans 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/1/2010 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home, 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) nerc Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) signed by the a Id be detached fo 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Obstructive 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has within 24 hours after death.

To the Funeral Director; After this certificate has completed filled in by the funeral director, page 2: autopsy performe Yes 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 Good huck Rdy Elena M. Castro Lankam , mb. mD. Year) 31. Date filed (Month State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** January 21, 2010 8:54 PM Charnya Fisher /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Date of Birth (Month, Day, **Funeral** 1 □ M 2 🔼 F Months Days Hours 022-28-5192 12/24/1935 Mass. Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f shov 1X Yes 2 □ No Directo Montgomery Bethesda 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10221 Tyburn Terrace 20814 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
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1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 3 Ectopic pregnancy Month Year Day 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2**X** No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

Aaron Snyder

10

9901 Medical Center Drive 31. Date filed (Month, Day, Year) 32. Registrar's Signature arke JAN 26 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DS9929

Rockville, MD 20850

January 22,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 23, 2010 James Addison Farran 12:45 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice-Casey House **Rockville** Mon topmery 6. Sex 1 M 2 D F If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year Aug. 4, 1951 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) D.C. 220-58-7986 58 Director Yrs Usual Residence of Decedent 28a-f shov 10a. State 10h County 10c. City, Town or Location Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 🔼 No P.G. Maryland Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2130 Saranac Street 20783 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces? 1 X Yes 2 N 交 1 Never Married 2 Married If Yes Give 1986-89 1 ☐ Yes 2 TNo Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Computer Technician Technology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H ၉ Samuel Webster Farran Lorraine Catherine Fink permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ken W. Farran/Brother 6711 Old Stonehouse Lane, New Market, MD 21774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan. Date 25, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 4 Donation 5 Other (Specify) Alexandria, Virginia 2010 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Signatu of Funeral Service Licens Vart 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ End-Stage Liver Disease Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be phys the L IF FEMALE: Jse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ atten for u in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed | 23e. Did tobacco use contribute to the cause of death? þ Alcoholism, Acute Renal Failure 1 🗌 Yes Completed 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 💾 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Other (Specify) Hospica 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury Certificate: injury X Natural 5 Pending 1 Yes 2 No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Box 68760 P.0. Records, the Hospital or Attending Physician: **Division of Vital** To the Hospital or Alteria..., within 24 hours after death.

To the Funeral Director: After completed filled in by the fu

Baltimore, Maryland 21215-0036

Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature 29d. Date signed (Month, Day, Year) January 23, 2010 5+1 monand ess of person who completed cause of death (Item 23a) (Type, Print)
Puthumana, MD 201 E. University Pkwy., Baltimore, MD 21218

ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29a. Certifier

Joseph J.

31. Date filed (Month, Day, Year) JAN 26 2010 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - State Registrar	State of Marylan		rtificate of			Reg. No.	3. Time of Death
ysician	Decedent's Name (First, Middle, La Prince	Forbin				Jan. 2		1140
Medical caminer	4a. Facility Name (If not institution, gi			4b. City, Town, or	Location of Death		4c. County o	
neral ector		ospital Sex 7. Age (In yrs. 1⊠ M 2□ F	last birthday) Yrs.	Silv If Under 1 Year Months Days 1 4	er Spri If Under 24 Hrs. Hours Min.	ng 8. Date of Bir (Month, Da 1 / 1 5 /	th ly, Year)	tgomery 9. Birthplace (State or Fore Country) Maryland
<u></u>	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	v. Town or Lo	ocation				10d. Inside City Lim
fied at	MD Montgo	omery Si	lver	Spring				1 □ Yes 2 汉
Sirec	10e. Street and Number			10f. Zip Code			10g. Citizen of WI	nat Country?
ale la	14511 Layhill	·		209			USA	A Landing
edical Examiner must be notified at leted by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 □ No	Ispanic Origin? (Sp an, Mexican, Puerto Specify:	pecity Yes of No Pican, etc.)	Specify:	- American Indian, , White, etc. .Black
eted	15. Decedent's E	ducation ade completed)	16a. Dece	dent's Usual Occup	ation during most of work	kina	16b. Kind of Bus	iness/Industry
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retired none	d)	9	none	
Be Completed	17. Father's Name (First, Middle, Las	t)		1.01.0	18. Mother's Nam	e (First, Middle	, Maiden Surname	
To Be	Stephen Forbi				Lucia	Nkafu	1	
To	19a. Informant's Name/Relationship	(Type. Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Numb	er, City or Town, S	State, Zip Code)
	Stephen Forbir							ng,Md 2090
once,	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (5) of	_ Hemoval from State	ate of	osition (Name of matory or other place Heaven	2/02	/2010	Silver	City or Town, State Spring, Md
once	21. Signatur Funeşal Service Lio	Me .	92	241 Colu	mbia Bl	vd.Sil	ver Spr	ICE,P.A. ing,Md2091
ian	23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition	nplications that caused the deat one cause on each line.			ng, such as cardiac	or respiratory a	ırrest,	Approximate Interval Between Onset and Death 14days
eal ier	resulting in death)	Due to (or as a conseq						14days
Examiner	Sequentially list conditions, if any, leading to instruction cause. Enter Underlying Cause (Disease or injury that initiated events	b. Extreme F		Lurrcy				: 4days
edical Examir	resulting in death) Last	Due to (or as a conseq	uence of):					
ian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of 6 9 Unknown	al death 3	☐ Ectopic pregnand	ру		23d. Date Mon	e of delivery th Day Year
§	Part II. Other significant conditions	contributing to death but not res	ulting in the u	ınderlying cause giv	ven in Part I.			bute to the cause of death?
omp						24a. Was auto perfo	ppsy pormed? d	/ere autopsy findings availa rior to completion of cause eath? □Yes 2 □No
rector, page	25. Was case referred to medical examiner?	111		100	26. Place of Dea	th (Check only	one)	
	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Toppatient 2 28a. Date of Injury	ER/Outpatie		4 LI Nursing H		idence 6 Othe	
tion	1 XNatural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	Wor	k? lYes 2 □ No	200. Describe	now injury occurre	
Certification:	3 Suicide 6 Could not determine	be 29e Place of Injury - At h	ome, farm, st fy)	reet, factory, office		28f. Location (City or To	(Street and Numbe wn, State)	er or Rural Route Number,
Medical Cer		Physician: To the best of my knowning: On the basis of examination and manner stated.						
M	29b. Signature and title of certifier	(`	29c. Licens			,	(Month, Day, Year)
	Medica	COLD MI	ر	05	5515		0/29/	2010
	30. Name and address of person who					3		
Chata	Andrea Lotze 31. Date filed (Month, Day, Year)	MD 15(rest Gle	en Rd Si	iver S	pring,M	Id 20910
State	FFR 0.2 201	n / Linespoint of Organ	1.	10 B				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 25, 1:00 P M Abraham H. Feuer 2010 January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Arden Court Assisted Living Kensington 9. Birthplace (State or Foreign Country)
New York If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/15/1924 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Days Hours 1 ☑ M 2 □ F 087-18-1082 86 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD 14 Yes 2 □ No Director Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20906 15107 Interlachen Drive, #1006 USA death v Completed by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No 1942—
If Yes, Give
Year or Dates: 1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐Yes 2 No 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 72 New York State Elementary/Secondary (0-12) College (1-4or 5+) Insurance Fund permit. Pages 1 and 2 should be filed with Department of Health, and Mental Hygiene Important: If Item 27 is marked other that any Injury or other traumatic event, It alone. Auditor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sam Feuer Rose Liebman ည 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mitchell Feuer-Son 1628 S Street, NW, #2 Washington, DC 20009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 1 Cremation 3 1 Removal from State 1/31/2010 Falls Church, VA 4 □ Donation 5 □ Other (Specify) National Crematory 22. Name and Address of Facility Danzansky-Goldberg Memorial 21. Signature of Funeral Service Licensee Jamie Arthurs Chapels, Inc. 1170 Rockville Pike Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Congestive Cardiomyopathy /Medical Due to (or as a consequence of): **Examiner** Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Dementia and burial-trar Due to (or as a consequence of): Box 68760. physician Physician/Medical the attending for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No o detached 9 Unknown 9 Unknown ٣. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ should be 2X No 1 ☐ Yes 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an has page 2 autopsy performed? Yes 2X No certificate 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specific Ving 1 ☐ Yes 2 🖾 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated the within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe ၉ H.D

State Registrar 30. Name and address of person who co

29

Alpana Goswami,

JAN

31. Date filed (Month, Day, Year)

pleted cause of death (Item 23a) (Type, Print)

Registrar's Signatu

Rockville

11125

M

2010

D-27660

Pike Suite 110 Rockville, MD 10852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 10 04219 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certific	ate of	Death		,	,	Reg. No.		
Physic		1. Decedent's Name (First, Middle,Last) 2. Date of Death								3. Time of Death		
Medical Exam	ine	margaret	Greig Farr						Month February	2, 201	Year 0	1600 hrs
		4a. Facility Name (if not institutio	-		4	b. City, Town, o	or Location	of Death			County of Dea	th
		7715 Savannah Drive				Bethesda				M	ontgomery	
Funeral		Social Security Number	6. Sex 7. Age (In yrs, last bir	hday)	If Under 1 Ye Months Da					TEOre	irthplace (State or
Director	1	318-46-6428	1 M 2 X F 5	7	Yrs.	Months Da	ys Hours	s Min.	Aug.	10,	1952	country) IL
,		Usual Residence of Decedent										
, under 1		10a. State 10b. County	10	Dc. City, Town	or Location	on						10d. Inside City Limits
Maryland 28a-f show any d at once,	٥	Md Montg	omery	Bethes	da							1 X Yes 2 No
Mary 28a-d at c	Director	10e. Street and Number				10f. Zip Code				10g. Citize	en of What Co	untry?
the Sa or	<u>ã</u>	7715 Savannah	Dr			2081	L 7			US	A	
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f shoent, the Medical Examiner must be notified at once.	Funeral	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. Was	Decedent of H	ispanic Orig	gin? (Spec	ify Yes or N			rican Indian, Black,
death or ite	ڃَ	1 Never Married 2 Ma	arried Armed Forces?	No	lf Ye	s, specify Cuba	n, Mexican	ı, Puerto Ri	can, etc.)		White, etc.	
after al", o	by F	3 X Widowed 4 Dive	orced If Yes, Give Year		1	Yes 2 X No	specify:			s	Specify:	White
ours natur	귷	15. Decedent's Education (Spec	ify only highest grade comple		Decedent'	s Usual Occupa	ation (Give	kind of wor	k done	16b. Ki	nd of Business	/Industry
6 n 72 h an "r	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	'	Juling IIIO	st of working life	e. DO NOT	use retired	1)			
003 within iene. er th	Ĕ		5+	C	linio	al Psyc	cholog	gist		P	sychol	ogy
Hyg	ပိ	17. Father's Name (First, Middle,	Last)				18.Mother	's Name (F	irst, Middle,	Maiden S	Gurname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		Herbert Wall	ace Greig				Sh	irley	McNai	lr Ha	wkins	
ID 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hyggene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	P	19a. Informant's Name/Relationsh		3.7		Address (Stre						e, Zip Code)
Z d d Z		Alexandra M Fa	<u>rr / Daughter</u>			avannal						
ore, of He of He of her to			3 Removal from State		ory or other	ion (Name of ce er place)	emetery,		ate	20c. Lo	ocation - City o	r Town, State
Page Page nent ant: or oth		4 Donation 5 Other Sp			ona1	Cremato	ory	Feb.	12,10	Fa1	ls Chu	rch, Va.
Baltimore, permit. Pages 1 an Department of Hea Important: If iter injury or other tr.	l li	21. Signature of Funeral Service I			22. Na	me and Addres	s of Facility	Jose	ph Gav	ler'	s Sons	
		William K. E	Lugar		513	0 Wisco	nsin	Ave 1	N.W. W	lashi	ngton 1	OC 20016
Physician		23a. Part I. Enter the disease, or of failure. List only one cause of	complications that caused the on each line.	death. Do no	t enter the	mode of dying	, such as ca	ardiac or re	spiratory an	est, shock	k, or heart	Approximate Interval Between Onset and
/M dirai	8 17	Immediate Cause (Final disease	a Cardiac ar	rhythm	ia as	sociate	ed wi	th ca	rdiome	galy	and	Death
		or condition resulting in death)	Due to (or as a conseque	ence of): hy	pothe	rmia						
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	ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence.	ence of);								
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):								
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760, icate be physic the bun	ŝ	IF FEMALE:		of pregnancy	реги	111 g g J U I	L 3/3/	/10 1	<u> </u>	23d.	Date of deliver	<u></u>
68° certifications de as la		23b. Was decedent pregnant in the past 12 months?	Live birth	2	Feta	death 3	Ectopic	pregnancy	,	М	lonth	Day Year
Box 68	Physician	1 Yes 2 V No 9 Unkr	nown 9 Unknown	e or death 5	Othe	(Specify)						
D. B t the d by the	튄	Part II. Other significant condition		it not resulting	in the un	dorlying course	nivos in Ba	et I	230 Did to		a aastribusta ta	the cause of death?
, P.O. ires that the signed by be detach	à				in and an	adilying cadde (giveir iii i zi	rci.				bably 4 V Unknown
ords, F w requires s been sign should be	ted	<u>CHronic alc</u>	OHOLLSIII									
COFC law re has be	흺								24a. Was autop	sy	prior to	topsy findings available completion of cause of
tal Recidan: The location of t	Completed								1 ✓ Yes	rmed? 2 No	death? 1 ✓ Y	es 2 No
tal Rectant: The certificate ector, page	Be	25. Was case referred to medical examiner?					of Death (Check only	one)			
Division of Vital Records, tal or Attending Physician: The law require rs after death al Director: After this certificate has been sited in by the funeral director, page 2 should be to be the funeral director.	2	1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 ER/Ou	tpatient	3 DOA	Other4	Nursing H	ome 5	Residenc	e 6 🗸 Othe	r: Scene
1 of Jing Ph After t	Ë	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. T	ime of Inju		ry at Work?	51	Describe	now injury	occurred osed to	cold
ttend feath the:	¥	Pendii	ng igation Fd 2/2/10	Fd	3:58	pm 1 1	Yes 🏋	No	nviron	•		, сота
ivis or At after d Direct	븳	3 Suicide 6 Could	not be 28e. Place of Injury	- At home, far	m, street,	factory, office b	uilding, etc					ral Route Number, City
Div spital or cours afte neral Dii filled in	Certification:	4 Homicide determ	nined (Specify) For	und: r	eside	nce			thesd			initian DE
e Hos 124 h e Fur letely		29a. Certifier (Check only 1 Certifying Phy	ysician: To the best of my kn	owledge, deat	h occurre	dat the time, da	ate and plac	ce, and due	to the caus	e(s) and r	manner as stat	ed.
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	edical		niner:On the basis of examina and manner stated.	ation and/or in	vestigatio	n, in my opinion	, death occ	curred at the	e time, date	and place	, and due to th	e cause(s)
5-PEUD	Ž	29b. Signature and title of certifier				29c. Licens	e number			29d. Da	te signed (Mo	nth, Day, Year)
will the same		hig his	, wo			O.C.1	M.E.			Febru	ary 3, 2010)
	I	30. Name and address of person w	vho completed cause of death	(Item 23a)								-
	[Ling Li, MD Assistan	t Medical Examiner	111 Penn	Street,	Baltimore,	MD 2120	01				
		31. Date filed (Month Pay (eff.)	2010 32 Registrar's S	ighatue	back	1						
Regist	rar		Comme	1. 1	444							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mar	yland / Depa		Health and Men Death	•	ne 2 N I N	04220
	Dharisi		1. Decedent's Name (First, Middle, La	st)				ate of Death	Day Year	3. Time of Death
	Physici /Medic		Wanda Moore	Foxwell			1 1		6,2010	2210 M
	Examir	er	4a. Facility Name (If not institution, giv				r Location of Death		4c. County of Death	
The state of the s			Salisbury Rehab	ilitationa N	ursingCtr	Salis	sburg		Wicom	ica
	Funeral		5. Social Security Number 6. S	Sex 7. Age (☐ M 2 💢 F	In yrs. last birthday) Yrs.	If Under 1 Year Months Days		ate of Birth Month, Day, Yes		nplace (State or Foreign untry)
	Director		216–14–9723 Usual Residence of Decedent		85 Yrs.		Ma	rch 23	1924 Mar	ryland
1	land ow		10a. State 10b. County	1	Oc. City, Town or Lo	cation				10d. Inside City Limits
5	Many Frank	tor	MD Wicom	ico		Sal:	isbury			1 ∐Yes 2 √∑ No
R	with the Maryland a or 28a-f show	irec	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	untry?
X2	h wit	Completed by Funeral Director	1806 E. Clearla	ke Drive			21804		USA	
⇒ `	death	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H	dispanic Origin? (Specify `an, Mexican, Puerto Ricar	Yes or No-	14. Race - Amer	
യ്ക	or Ite	/ Fu	1 ☐ Never Married 2 ☐ Married	1 ☐Yes 2X No		1 □Yes 2 TNo		i, eic.)	Black, White	
€ 10036	72 hours after natural", or Ite	q p	3 ₩ Widowed 4 □ Divorced	Year or Dates:						hite
× 5	"nat	lete	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	(Give	dent's Usual Occup kind of work done	during most of working	16b.	. Kind of Business/li	ndustry
72	withir ene. than	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)	me.	DO NOT use retired homemake			own home	<u>,</u>
9	filed within Hygiene. other than " ent, the Me	ပို	17. Father's Name (First, Middle, Last,)			18. Mother's Name (Firs	st, Middle, Maid		
Maryland	d be ental ked d	To Be	Herbert A. Moo	re			Hazel Dy		,	
7	should I and Men s marke umatic	-	19a. Informant's Name/Relationship (19b. Mailii	na Address (Street	and Number or Rural Ro		lv or Town. State. Z	in Code)
(and 2 ealth a n 27 is ier trau		Gary C. Foxwell	son			ake Dr., Sa			
je,	s 1 al		20a. Method of Disposition		20b. Place of Dispo cemetery, crei	esition (Name of	Date DI.		Location - City or T	
$\mathcal{Z}_{\mathbf{E}}$	Pages nent of int: If its iry or o		1 ☑Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	inemoval irom state	Maryland			10	Hurlock,	MD
(U) Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Moderal Examiner mast be notified at once.	Ì	21. Signature of Funeral Service Licer			2. Name and Addre	ess of Facility			
æ	B a E a		NS-K. P		7	00 Togust	St., Cambr		ral Home D 21613	P.A.
			23a. Part I. Enter the disease, or com shock, or heart failure. List only	plications that caused the	e death. Do not ent	er the mode of dyir	ng, such as cardiac or res	piratory arrest,	- 21013	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	one cads on cach line.	2-08	- /				Onset and Death
	/Medical		resulting in death)	Due to (or as a c	onsequence of);					quar.
	Examiner		Sequentially list conditions	b					ı	
	ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death.) Leat	Due to (or as a c	onsequence of):					
	xecut and I-tran	хап	that initiated events resulting in death) Last	cDue to (or as a co	onsequence of):					
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587	ficate phys s the			d						
×	nding nding use a	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p					, 23d. Date of deli	verv
ñ	death atte	cial	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tin		☐ Ectopic pregnanc ☐ Other (specify) _	У		Month	Day Year
0	t the by the achee	Physician/Med	9 Unknown	9 ☐ Unknown						
,	s tha gned e det	by P	Part II. Other significant conditions of	ontributing to death but n	ot resulting in the u	nderlying cause giv	en in Part I.	3e. Did tobacc	o use contribute to	the cause of death?
ord	en si							1 🗆 Yes	2 № 3 □ Pro	bably 4 Unknown
ec ec	law ra as be 2 sh	Completed						24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
<u> </u>	sician: The law certificate has t irector, page 2 si	E						performed	? / death?	2 □No
/ita	cian: ertific ector,	Be	25. Was case referred to medical examiner?				26. Place of Death (Cha			
)	hysi this o	ပ္	1 ☐ Yes 2 ☑ No	-	2 ER/Outpatier		4 Nursing Home	5 🗌 Residence	6 □Other (Spec	ify)
<u></u>	ing F	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Yo	ear) 28b. Time of Injury	Wor		Describ e how in	jury occurred	
Sic	ttend leath tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	. 4			Yes 2 □No			
Division of Vital Records, P.O. Box 68	or A	Certification:	4 ☐ Homicide determined	28e. Place of Injury building, etc. (- At nome, tarm, str Specify)	eet, factory, office	28f. L	ocation (Street City or Town, St	and Number or Rui ate)	ral Route Number,
	spital ours ours ieral filled		29a. Certifier 1 > Certifying Ph	vsician: To the best of n	ny knowledge, deat	h occurred at the ti	me, date and place, and c	lue to the cause	e(s) and manner as	stated
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 ☐ Medical Examone)	niner: On the basis of ex and manner stated	amination and/or in	vestigation, in my o	ppinion, death occurred at	the time, date	and place, and due	to the cause(s)
	To th Withir To th Comp	Me	29b. Signature and title of certifier	1		29c. Licens	e number	29d. I	Date signed (Month	, Day, Year)
	,			here		02	9549	1	28/18	
	10		30. Name and address of person who	completed cause of deat	h (Item 23a) (Type,	Print)	0		1	
			William H. Rob	Pins, M.D.	200 Ci	vic Ave	, Salisbu	ryin	D 218	24
	Sta	re.	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	bark		7		
	Registr	ar	JAN 28	UIU DOM	J 19 19					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician Virginia Evelyn Flickinger 0 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County General Westminster Carrol1 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 279-50-0239 60 Director Aug.1, Michigan 1949 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-1 shov any Injury or other traumatic event, It is Medical Examinar must be retified at Director Carroll 1 ☐ Yes 2 X No Maryland Taneytown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5150 Harney Road 21787 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2/☐ No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner & Operator Commercial Cleaning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles H. Marine 2 Grace Garland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Flickinger / Husband 5150 Harney Rd., Taneytown, MD 21787 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Mountainview Cemetery 1/24/2010 Harney, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 Tau 23a. Rard. Enter the disease, or complications but caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** VIULTIPL /Medical Due to (or as a consequence of) Examiner ESPIRATOR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed MONAR and burial-tran Due to (or as a consequence of) signed by the attending physician be detached for use as the burial Box 68760, GE ADENOCARCINOMA Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3

Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has autopsy performed? Yes 2 100 this certificate of Vital 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 → No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) s after death.

I Director: After the din by the funeral 27. Manuar of Death 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 / Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ∩ 24 hou. the Funeral Dire 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the F and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MAHBOOB D54339 20 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAH BOOB ASHRAF, M 7D WESTMINSTER MEMORIAL 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2010 ▶ Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen 04222 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year SYDNEY FOXWELL JANUARY 30A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours (Month, Pay, Mary Land 83 219-22-9545 **Director** an. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 ☐ Yes 2 🗵 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7910 Juniper Drive 21702 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 1 XX Yes 2 🗌 No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify: If Yes, Give "natural", Completed 3 Widowed 4 Divorced WWII Year or Dates. ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N College (1-4 or 5+) Publishing Photography Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Holly Foxwell Margaret Wolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia Foxwell / Wife 7910 Juniper Dr. Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) January 26. 1 Burial 2 X Cremation 3 Removal from State Resthaven Crematory 4 Donation 5 Other 2010 (Specify) Frederick, Maryland 21. Signature - Fur eral Service Reschaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwv. Frederick, MD 23a. Part 1. Enter the disease, shock, or heart failure. List implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or indition resulting in death) Vas cut Medical o (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed and use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): within 24 h urs after death.

To the Fun ral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 Yes 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) ည 1 Tes ER/Outpatient 3 DOA 1 Inpatient 2 Certificate: Manner of Dea 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident injury 5 Pending work?
1 Yes Investigation 2 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and a second control of the basis of the basi tigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the I within 2 unly one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) a 3 se of death (Item 23a) (Type, Print) 30. Name and address of person who completed car

10+1

Registrar

State

Robert L. Kaufmann, M.D.

31. Date filed (Month, Day,

32. Registrar's Signature

300 West 9th Street, Frederick, MD 21701

Division of Vital Records, P.O. Box 68760
To the Hospital or Attending Physician: The law requires that the death certificate be executed
Within 24 Hours after dearn. To the Funeral Director: After this certificate has been signed by the attending physician and
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12		30. Name and addre	ess of person who	completed cause of d	eaur (item	23a) (Ty)	e, Print)		5606	<i></i>		L	aliuc	ary 2	29, 2	010
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Amend 20b, per Fh 9901 3/12/10 TT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ EBRU Howard Lee Furr Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Prince George's Lanham 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Wash., D.C. 8. Date of Birth **Funeral** 1 🔀 M 2 🗆 F Months Days Min. Hours 0770171942 67 Yrs Director <u>577-56-0956</u> Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits 28a-f Lanham 1 Yes 2 No Md. P.G. 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 4502 Havelock Road 20706 U.S.A. items ? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc.
African—
ecify: American ō þ 1 Never Married 2 Married 2 No If Yes, Give 160-163 1 ☐ Yes 2 🙀 No Specify: "natural", 3 ☐ Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Computer Analyst/FDIC U.S. Government years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Victor L. Furr Allethia V. Conley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 3617 Village Drive North, Upper Marlboro, Md. 20772 Maria Denise Furr/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 02/09/10 Harmony Mem. Park Landover, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility H.S. Washington & Sons 4925 Burroughs Ave., N.E. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Yes 2 No ed by the 9 Unknown P.O. s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe certificate 1 Yes 2 No Yes 2 **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: To 1 Yes 1 Inpatient 2 FR/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 1 🛄 Natural filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar
DHMH 17 Rev 7/2009

State

o. Name and address of person who

FFR 0 4 2010

31. Date filed (Month, Day, Year

Good Luci

npleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 04225 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ HAZEL FAROUHARSON 2010 January 10:49a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number **Funeral** 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Country) Jamaica 1 M 2 StF Hours June 27, Year 1917 **Director** 217-30-1017 92 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene. tem 27 is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director DC 1 X Yes 2 ☐ No Washington 10e. Street and Number 10f. Zip Code r items 23a or ner must be n 10g. Citizen of What Country? Funeral 1200 Delaware Ave. 20024 IISA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian the Medical Examiner Armed Forces? Black, White, etc. þ ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Yes Give Completed 3 X Widowed 4 Divorced Specify: Year or Dates. Black 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8th Midwife Self Employed traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John True Susan True 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Reuben Leslie - Friend 608 Juneberry Ct. Bowie, MD. 20721 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of F
Important: If ite
any injury or oth 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Cem. 2-8-2010 Suitland, Md. 21. Signature of Superal Service Licensee Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitlnad, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Finysician/ Anemia Medical resulting in death) Due to (or as a consequence of): Examiner Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Myelodysplastic Syndrome Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy director, page performed? Yes 2 No Diabetes After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🔀 No ပ္ 1 x Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At completed filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D56691 1/30/2010

Registrar

State

12107 Heritage Park Circle

Silver Spring, MD.

30. Name and address of person who completed cause of death (Item 23a) (Thee, Print)

32. Registra 's Signature

MD

Ghousia Sultana,

31. Date filed (Month, Day, Year) FEB 0 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04226 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month O 9:03AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mandrin Chesapeake Hospice House Anne Arundel Harwood Social Security Number If Under 1 Year If Under 24 Hrs Funeral 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Hours Min 12/23/1958 New York Director 220-78-2132 51 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Direct Marvland Anne Arundel Annapolis 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1901 McGuckian Street, #332 21401 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 A No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Bace - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married Completed by 1 Yes : Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 X Divorced White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 feath and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Manager Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Durkin Flanagan Angela G. Ciampaglia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John D. Flanagan/Father 625 Admiral Drive, #7308, Annapolis, MD 21401 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Cemetery 20c. Location - City or Town, State Date permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 02/03/2010 Annapolis, Maryland 4 Donation 5 Other (Specify) Muneral Service Licensee 21. Signatur 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons <u>Island Road</u>, <u>Edgewater</u>, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examine Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No 9 Unknown the Unknown Division of Vital Records, P.O. ed by t detach s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed Yes 2 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month) Day, Year) Name and address of person who completed cause of death (Item 23a) (Type

State Registrar SUSAN

31. Date filed (Month, Day, Year)

FEB 01

State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c, County of Death Hospital (5. Social Security Number presient 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 M 2 □ F Months Days Min (Month, Day, Year) Director None Usual Residence of Decedent 28a-f show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director MD Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7903 Colonial Lane 20735 United States within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Armed Forces 1 Never Married 2 Married Yes 2 No ģ Baltimore, Maryland 21215-0036 1 ☐ Yes If Yes, Give 1 X Yes 2 □ No Specify: Mexican Specify: Caucasian 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Never Worked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked of any Injury or other traumatic eve ည 19a. Informant's Name/Relationship (Type, Print) /Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Guadalupe Pereyra-Diaz 7903 Colonial La., Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 01/24/2010 Atlantic Crematory Glen Burnie, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Thibadeau Mortuary Service, 7 Park Avenue, Gaithersburg M00956 Avenue, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ARRIDPULMON Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ysician and le burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Box 68760 nding physi use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 2 No 3 ☐ Probably 4 ☐ Unknown Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an Was an autopsy performed? of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) : After this funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work?
1 Yes 2 No Division within 24 hours after death.

To the Funeral Director: Af completed filled in by the ful Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

9. Birthplace (State of Foreign

10d. Inside City Limits

Approximate Interval Between

Onset and Death

1 Yes 2 No

N

Black, White, etc.

Month

Day

16:00 PM

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GALL

482170

Registrar's Signature

0 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral 01228 Reg. No. Z U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MABLE ROWENA GASSAWAY 01/20/2010 1452 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2X F 217-30-0053 03/04/1923 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Gaithersburg Montgomery 10e. Street and Number 10g. Citizen of What Country? 17650 Amity Drive, #104 20877 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: 3€ Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stansbury Frazier, Sr. Vernese M. Claggett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Plummer - daughter 17720 Garrett Drive, Gaithersburg, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Brooke Grove Cem. 1/27/10 Gaithersburg, MD 4 Donafon 5 Dother (Specify) 22. Name and Address of Facility 21. Signatu of Funeral Service Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the dise ise, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failule. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Bacteremia sepsis Due to (or as a consequence of) Pneumonia Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Dunknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

I or Attending Physician: The law requires that the death certificate be executed after clearly.

Director: After this certificate has been signed by the attending physician and air by the funeral director, page 2 should be detached for use as the burital-transit air by the funeral director, page 2 should be detached for use as the burital-transit

Box 68760,

P. 0.

Division of Vital Records,

Physician

Examiner

10a. State

MD

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

'natural"

other than "natu

27 is marked or traumatic even

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permit. Page Department of Important: If any Injury or once.

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or

Baltimore, Maryland 21215-0036

Director

Funeral

þ

Completed

Be

ပ

the Maryland

/Medical

Exami Physician/Medical ð Completed Be Certification: To

23b. Was decedent pregnant

Acute renal failure

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown 24a. Was an autopsy 1 ☐ Yes 2 1 No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical Hospital: 1∐Yes 2XNo 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 1 XNatural 5 Pending

investigation 6 ☐ Could not be

determined

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

2 Accident

4 Homicide

3 Suicide

29a. Certifier

68178

29d. Date signed (Month, Day, Year)

01-20-2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Santosh Rane 9901 Medical Center Drive, Rockville, MD 20850

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

filled in by

Medical

within 24 hours a
To the Funeral L Hospital

the

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10

31. Date filed (Month, Day, Year, JAN 2 6 2010

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Registrar's Signature

ane'MD

		A	Pleamend #25, per M	ase Type or Pri E G904 6/8/1 State of M	nt in E 0 TT aryland					ure A and N	All Copie Mental Hy	s Ar	e Legib e	le.	
	Physicia		1 - State Registrar 1. Decedent's Name (First, Middle Marianne B. Go	e, Last) ottschalk		Cer	tificat	e of <u>C</u>	Death		2. Date of De Month January		- U	ear	3. Time of Death 8:20 p M
	Medie Examir		4a. Facility Name (if not institution Suburban Hospital				4b. City,		Location of the Location of th	of Death		$\overline{}$	c. County of Mon t g		
	Funeral Director		5. Social Security Number 289–26–3224 Usual Residence of Decedent	6. Sex 7. Ag	e (In yrs. Ia 81	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Da Aug. 22,		3 9	Birthplace (State or Foreign Country) Germany	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important if fire Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10a. State 10b. County	gomery		, Town or Loc Kensingt		Code				10a C	itizen of Wha		d. Inside City Limits 1 Yes 2 No
40	r death with the or items 23a o	y Funeral	9619 West Bexhil 11. Marital Status 1 □ Never Married 2 및 Mar	12. Was Decedent E			20 Was Deced	895 lent of Hi	spanic Orl	gin? (Spe	ecify Yes or No Rican, etc.)	Ţ	JSA 14. Race - A	America	n Indian,
21215-0036	"2 hours afte "natural", c edical Exam	Completed by	3 Widowed 4 Divorced	If Voc Cive ""	No	16a. Deced	kind of wo	al Occupa k done o	ation		ing	16b. l	Specify: V		
d 212	led within 7 Hygiene. other than e nt, the M	Be Corr	Elementary/Seconday (0-12) 17. Father's Name (First, Middle, I	College (1-4 or 5	5+)		onoruse cansla	,	18. Moth	er's Name	e (First, Middle,			: Con	tracting
Maryland	12 should be fil alth and Mental 27 is marked r traumatic ev	ပ	Herman H. Besse	er		19b. Mailin	ng Address	(Street a	An	na M.	Trautve	tter		a, Zip Co	ode)
ore, M	of Health of Item 27 is rother tra		Charles M. Gotts 20a. Method of Disposition	·	20b. Pl		West	Bexh	ill Dr	ive,	Kensingt ———— Date	on, N		5	
Baltimore,	permit. Page Department Important: I any injury o		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (3 21. Signature of Funeral Service)	Specify) i ensee	Meta	ropolita	an Cre	nator	У		2010 eral Home		exandria		
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that caused only one cause on each line	the death								ing, MD		Approximate Interval Between
	hysician/ Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Toxic Er Due to (or as a									<u> </u>		Onset and Death
B	executed ian and irial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Find the details. Cause (Disease or iinjury that initiated events	b. Due to (or as a	a conseque	ence of):			- (1	NO BY HE	MALEX	AMINER		
	physician and the burial-transi		resulting in death) Last	Due to (or as a	a conseque	ence of):			CERTIFIC	ATION AP	PROVED BY ME				
Division of Vital Records, P.O. Box 68760	Within 24 hours after death. No the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 🗌 Fetal	death 3	Ectopic p Other (sp		у				23d. Date o Month		y Day Year
ds, P.O	en signed b	ted by P	Part II. Other significant condition Congestive Heart												cause of death?
Recor	ficate has be r, page 2 sh	Completed by	25. Was case referred to medical								1 Tyes	psy ormed?	prior deat	to com	y findings available pletion of cause of
/ita	s certi	To Be	examiner?	Hospital:	0 D F	R/Outpatien	+ 0 \(\sigma \)	Otho	r;						
n of \	h. After this funeral o		27. Manner of Death 1. Natural 5 □ Pendir	28a. Date of injur (Month, Day	ry 2	28b. Time of injury	2	Bc. Injury work	at ?	:	me 5 Resi 28d. Describe I			pecify)	
Divisio	rs after deat al Director: ed in by the	al Certificate;	2 ☐ Accident Investi 3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be		ne, farm, stre	M eet, factory		Yes 2 🗆		28f. Location (\$ City or Tov			Rural R	oute Number,
	in 24 hou he Funer	Medical	(Check 2 🖳 Medical E	Physician: To the best of xaminer: On the basis of ea Nurse Practioner: To the	kamination	and/or investi	igation, in r	ny opinio	n, death oc	curred at	the time, date a	and place	e, and due to	the caus	e(s) and manner stated.
	Mithin 2 To the I complete		29b. Signature and title of conficient	ryiz				License	number d265	71			nte signed <i>(M</i> nuary 28		
_			30. Name and address of person Irving Mizus, MD	who completed cause of de 10605 Concord				singt	an, MD	2089	95				
	Stat Registra		31. Date filed (Month, Day, Year) JAN 28 2	010 P. Registra	r's Signatu	re fau	20								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3:10a M Jeannette Glass 2010 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2011 Dundee Road Rockville Montgomery 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year _lf Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) New York 1 🗆 M 2 🕱 F Months Days Hours 1271771924 Director 116-14-5480 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2011 Dundee Road 20850 u.s.A Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 X Married þ ☐ Yes 2 **X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Mental Hygiene. narked other than "natural", natic event, the Medical Exa If Yes, Give 3 Divorced Specify. Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental i ည .. Page 1 and 2 should be it thent of Health and Ments tant: If item 27 is marked jury or other traumatic e Harry Kowitch Lillian Silbergeld 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2011 Dundee Road, Rockville, Maryland 20850 Albert Glass - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Crematory 01/28/2010 | Brentwood, Maryland 21. Signature of Funeral service Licenses 22. Name and Address of Facility Simple Tribute & Cremation Centur 1400709 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart railure. List only one cause on each line. Approximate Interval Between Onset and Death 2 Years Immediate Cause (Final Physician/ disease or condition resulting in death) Uremia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or finjury) Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Year Pregnant at time of death 9 Unknown 9 Unknown d be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Hupertension Completed 1 Yes 2 X No 3 Probably 4 Unknown been Ischemic Heart Disease 24a. Was an 24b. Were autopsy findings available this certificate has prior to completion of cause of death?

1 Yes 2 No autopsy Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No မ 4 Nursing Home 5 Nesidence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my know edge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

29b. Signature and title of certific

31. Date filed (Month, Day, Year)

Stephen Hellman,

30. Name and address of person who completed cause of death (Item 26a) (Type, Print)

M.D.

Registrar's S

Registrar

29c. License number

D20674

6240 Montrose Road, Rockville, Maryland 20852

29d. Date signed (Month, Day, Year)

January 27, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMFND#260crMD, 1–28–10, PMW, MCC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 20, Day 2010 Physician/ Candida 6:00 p Zaccaro Gargiulo Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Days Min 1 □ M 2 🖺 F May 12 Day 1925 577-54-4883 84 Ttaly **Director** Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits nours after death with the Marylanc Director 1 X Yes 2 □ No Maryland Montgomery Takoma Park rangivlo, Candid 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 519 Elm Avenue 20912 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 should be filed within 72 hours after and Merital Hygiene.

is marked other than "natural", If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 TDivorced Specify. White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nanny Child Care permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other tany injury or other traumatic event, this ones. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Angelo Zaccaro Benedetta Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. DiLuigi/Executor 7106 13th Avenue, Takoma Park, MD 20912 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Feb. 3, 2010 20c. Location - City or Town, State cemetery, crematory or other place)
Gate of Heaven Cemetery 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Sign ture Funeral Service Lycns e 22 Name and Address of Eacility Francis J. Collins Funeral Home Inc. Blekard L Males 500 University Blvd. West, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Cause (Disease or iinjury that initiated events and Exa burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical certificate be Box 68760 as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Year 5 Other (specify) Pregnant at time of death 9 Unknown P.O. signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Division of Vital Records, 2 No 3 Probably 4 Nuknown Completed 1 Yes page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autonsv perform death? certificate 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No ဂ္ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours area worth To the Funeral Director: After funeral Director: After funeral filled in by the funer (Month, Day, Year) Natural 5 Pending 1 🗓 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and 📶 0 e of certi 29c. License number 21 MU 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drewry James White, MD 20010 Century Blvd., #200, Germantown, MD 20874 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 28 2010

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04232 StateRegistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Miriam Ella January 23, 2010° 1:25A. M Gair Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 608 Elm Avenue Takoma Park Montgomery 5. Social Security Number 579–18–7575 6. Sex . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2**½** F Months Hours Min, 92 044enth284, 19917 New Jersev Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Takoma Park 1 Yes 2 □ No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20912 608 Elm Avenue United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White If Yes, Give 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Administrative Secretary Religious Institution Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillian Coleman Harold M. Britton, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 608~Elm Avenue Takoma Park, Maryland 20912 Kenneth L. Gair -son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MD Veterans Cemetery 2/1/2010 Cheltenham, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licens Bornald Wors Borg wardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Months Immediate Cause (Final Physician Pancreatic Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 ☐ Pregnant at time of death g ☐ Unknown 5 Other (specify) Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Coronary Artery Disease; Hyperlipidemia; 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a Was an performed? Yes 2 ANO death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐XNo Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Investigation Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D6100 January 25, 2010

Registrar
DHMH 17 Rev 7/2009

State

Kenneth Khandagle, M.D. 12520 Prosperity Drive,#320 Silver Spring, Md. 20904

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signa

31. Date filed (Month, Day, Year)

JAN

28

10-00755 Jeffrey Gerrard Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

•		1- For State Certificate of Death		Reg. No.	0 420
Physic		Decedent's Name (First, Middle,Last)	2. Date of De Month	Day Year	3. Time of Death
dical Exar	mine	orizo, orane ourise	January	26, 2010 4c. County of Death	0208 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location Track 2 @ Hungerford Drive and Mannakee Street Rockville	on or Death	Montgomery	
Funera	al		nder 24Hrs. 8. Date of B	Birth (MM/DD/YYYY) 9. Birt Foreig	hplace (State or
Directo		400-74-6032 1XM 2 F 49 Yrs Months Days Ho	ours Min. Dec.	6, 1960 Foreig	n New ^{untry)} York
		Usual Residence of Decedent		-,	
w any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
land fsho		MD Montgomery Clarksburg			1 Yes 2 X No
Mary r 28a	Director	10e. Street and Number 10f. Zip Code 23501 Peach Tree Road 20871	i	10g. Citizen of What Cour United St	*
with the Maryland ms 23a or 28a-f show			Origin? (Specify Yes or)		
eath w	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexic		White, etc.	
after de	by Ft	3 Widowed 4 Divorced If Yes, Give Year 1981-1990 1 Yes 2 X No spec	sify:	Specify: Wh:	Lte
hours	ed b	AF Bandarda Education (Caralte and bishort and associated) ACC Bandarda United Committee (City		16b. Kind of Business/l Washington	
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5-00; led with tygiene other t	Completed	17. Father's Name (First, Middle, Last) 18.Mot	her's Name (First, Middle	Aut , Maiden Surname)	nority
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Tis marked other than "matural", or items 23a or 28a-f show it marked other than "and a featural".	Be C	Gerald Garrard Sa	rah Jane Pl	ace	
21 nould lid Mer	2 اؤ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and N	Number or Rural Route N	umber, City or Town, State	Zip Code)
∑ 242	ranmat	Grace Ann Garrard / Spouse 23501 Peach Tree 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,		20c. Location - City or	
Ore,		1 Burial 2 X Cremation 3 Removal from State crematory or other place)	January 27, 2010		
t. Pag	9 0 0	4 Donation 5 Other Specify: 21. Signature of Feneral Service Licensee Metropolitan Crematory 22. Name and Address of Fac		Virgi	11a
Baltimore, permit. Pages I am Department of Heal Important: If iten	a l	124a, 1 more Moning Devol Funeral Gaither	Home, 10 E	ast Deer Par	k Drive,
Physicia	_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a			Approximate Interval
/Medica	al	failure. List only one cause on each line. Immediate Cause (Final disease a Multiple Injuries			Between Onset and Death
-xamme		or condition resulting in death) Due to (or as a consequence of):			
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examin	cause. Enter Underlying Cause (Disease or injury that initiated			
od d	Exa	events resulting in death) Last Due to (or as a consequence of): d.			
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed releath. retearh. After this certificate has been signed by the attending physician and exercity. After this certificate has been signed by deached for use of the burial pression.	ledical	UNPENDED AMENDED		-	
760, cate by	/Med	1F FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery	
Box 687 Heath certification of for use 3.5 the	sician/	past 12 months?	opic pregnancy	Month D	ay Year
Box e death the atte	hysic	1 Yes 2 No 9 Unknown 4 Pregrant at time of death 5 Other (Specify) 9 Unknown			
P.O. I	5 ₾	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in		tobacco use contribute to t	
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tal Reco	Completed		1 ✓ Yes	formed? death? 2 No 1 ✓ Ye	s 2 No
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of Vital Records, ag Physician: The law require the this certificate has been simpled director mans 2 should be been simpled the state of the state	티	1 V Yes 2 No 1 impatient 2 EROUtpatient 3 DOA 4	Nursing Home 5	Residence 6 Other	Scene
on of adding Pl	Certification: T	1 Natural 5 Pending Jan 26, 2010 0152 hrs 11 ✓ Yes 2	Pedestrian	struck by motor veh	nicle
Division tal or Attendir rs after death. al Director: A	fication	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building,		(Street and Number or Run	al Route Number, City
Divi Hospital or 24 hours afte Funeral Dir	erti	Suicide 6 Could not be determined (Specify) Metro Tracks	or Town, Track 2 @ F	State) lungerford Drive and Ma	annakee , Rockville,
Divis To the Hospital or A within 24 hours after. To the Funeral Directory of the Completely filled in the completely fi		Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and			
To the within To the	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated			
12+	دا،	29b Signature and little of certifier 29c. License numb	per	January 26, 2010	
	ч	// /n % // // // / 7			
	`	Octor Hallen Heek O.C.M.E.		Gandary 20, 2010	
		O.C.M.E. 30 Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimo	ore, MD 21201	oandary 20, 2010	

10-00951 William Louis Glodt

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physicia	n/	Decedent's Name (First, Middle,Last)					2. Date of Dea Month		3. Time of Death
Medical Examir		William Louis Glodt					February	2, 2010	1159 hrs
		4a. Facility Name (if not institution, give street ar 4015 Rpxmill Cpurt	nd number)	41	o. City, Town, o Glenwood	r Location of D	eath	4c. County of Deat Howard	1
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Ye	ar If Under 2	4Hrs. 8. Date of Bi		thplace (State or
Director		081-32-2029 1 X M 2		37 Yrs.	Months Da		Min.	Forei	ountry) NJ
iow any		10a. State 10b. County		own or Location	n				10d. Inside City Limits 1 Yes 2 No
aryland 8a-f show at once.	핡	MD Howard 10e. Street and Number	Glen	wood T	10f. Zip Code		1	0g. Citizen of What Cou	
th the Maryland 23a or 28a-f sho notified at once.	Director	4015 Roxmill Ct.			2173	38		United S	tates
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. nnt: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married 1 Arm	s Decedent Ever in U.S. ed Forces? /es 2 No				P (Specify Yes or No uerto Rican, etc.)	White, etc.	ican Indian, Black,
s after	칡	or Dates:	e Year 1943-63		Yes 2 X N				hite
hours af "natural"		15. Decedent's Education (Specify only highes Elementary/Secondary (0-12) Colle	ege (1-4 or 5+)		s Usual Occup st of working lif			16b. Kind of Business	Industry
36 hin 72 e. than '	Completed	Clementary/decordary (0-12)	5+	Ele	ctrical	l Engin	eer	Defense C	ontractor
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21215-003 uld be filed withi Mental Hygiene. marked other the	B	Louis Leo Glodt				and the second second	ian Murph	-	
MD 21; nd 2 should the lith and Mer m 27 is mar	우	19a. Informant's Name/Relationship (Type, Print Eileen F. Glodt - Wif	7.4				r or Rural Route Nur enwood,M	nber, City or Town, State D 21738	e, Zip Code)
Baltimore, ME permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum:		20a. Method of Disposition	20b. Pla	ce of Disposit	ion (Name of c		Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I an Department of Hee Important: If iter	1	1 Burial 2 Cremation 3 Remo 4 Donation 5 Other Specify:	vai il oili State	matory or othe e of H∈	aven Ce	em. 2	/5/2010	Silver S	bring, MD
altir mit. I partm porta	ł	21. Signature of Funeral Service License.	7	22. Na	ame and Addre	ss of Facility	Harry H.	Witzke's Fa	mily F.H. Ir
	1	Thoma Glis- Whit						licott City	
Physician /Medical	1	23a. Part I. Enter the disease, or complications t failure. List only one cause on each line.				g, such as card	lac or respiratory ari	est, shock, or heart	Approximate Interval Between Onset and Death
kaminer	1		clerotic Cardiovas	scular Dise	ase				Deati
		Sequentially list conditions, b							
	ji.	if any, leading to immediate cause. Ever Underlying Cause (Disease or injury that initiated	r as a consequence of):						
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Division of Vital Records, P.O. Box 68760, for the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	UNPENDED AMENT	DED						
3760, ficate be g physic		23b. Was decedent pregnant in the	yes, outcome of pregnal		al death 3	Ectopic pr	egnancy	23d. Date of deliver Month	y Day Year
Box 687 c death certific the attending I	Physician.	past 12 months?	Pregnant at time of death	_ =	er (Specify)			1	,
BO) he death	hys		Jnknown	Winner Control		-i i- D	220 Did4	obacco use contribute to	the eques of death?
P.O.	≦	Part II. Other significant conditions contribut Cerebral Infarction, Pnuemonia	ing to death but not rest	aiting in the ur	ideriying cause	given in Part i		s 2 No 3 Pro	
ords, P w requires t	ed			•					utopsy findings available
Vital Recor nysician: The law I this certificate has b	Completed						autor	rmed? death?	completion of cause of
tal Rection: The certificate ector, page		25. Was case referred to medical			26.Pla	ce of Death (Ch		2 No 1 Y	es 2 No
Vita ysicia this ce direct	To Be	examiner? 1 • No Hospital: 1	Inpatient 2 El	R/Outpatient	3 DDA	Other N	lursing Home 5	Residence 6 🗸 Othe	r; Scene
ling Ph After t		27. Manner of Death 28a.	Date of Injury 2 Month, Day,Year)	8b. Time of In		ury at Work?		how injury occurred	
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Division of Vital Records, P.O. within 24 hours after death. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be deated.	Certification:	Suicide Could not be	Place of Injury - At hom ecify)	e, rami, street	i, ractory, office	building, etc.	or Town, S	Street and Number or Ro State)	drai Roule Number, City
Hospit 24 hou Funer tely fil		29a. Certifier 1 Certifying Physician: To th	e best of my knowledge	, death occurr	ed at the time,	date and place	, and due to the cau	se(s) and manner as sta	ted.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the b	easis of examination and iner stated.	or investigation	on, in my opinio	on, death occur	red at the time, date	and place, and due to the	ne cause(s)
F * F 0	ž	29b. Signature and title of certifier				nse number		29d. Date signed (Mo	
		4M	1 /M	7	0.0	S.M.E.		February 3, 201	U
1041		 Name and address of person who completed Russell Alexander MD. Assista 	rcause of death (Item 23 int Medical Examir		Penn Stree	t, Baltimore	e, MD 21201		
St	ate		32. Registrar's Signature		ike				
Regist	rar	I FD 0 4 7010	house &	· jugares				OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04235 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ FEBRUARY 1° 2010 ear GRIER FRANK Ε. 11:52A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL MONTGOMERY SILVER SPRING Social Security Number Sex 14 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months Days Hours 1 1 - 2 - 1 9 2 1 NORTH CAROLINA 239-26-9262 Director 88 Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director Yes 2 No MD PRINCE GEORGE SPRINGDALE 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23aFuneral should be filed within 72 hours after death with 9107 UTICA PLACE 20774 U.S.A. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? 1X Yes 2 NoARMY or. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give "natural", 3 Divorced 4 Divorced Completed BLACK Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry Ind Mental Hygiene.
S marked other than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th TIRE SUPERVISOR PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ MARY MARSH CHARLIE GRIER permit. Page 1 and 2 should Department of Health and M Important: If Item 27 is mar any injury or other traumat once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NAOMI GRIER/WIFE 9107 UTICA PLACE SPRINGDALE, MD 20774 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 💹 Burial 2 🗆 Cremation 3 🗆 Removal from State ARLINGTON CEMETERY 2-11-2010 ARLINGTON, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME Signature of Funeral Service Licensee 7474 LANDOVER RD LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) RESPIRATORY FAILURE Medical Due to (or as a consequence of): Examiner MALIGNANT MESOTHELIOM Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death Other (specify) ned by the a 4 ☐ Pregnant a 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signe should be a Division of Vital Records, 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed Yes 24 page 2 certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred 1X Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0061937 Cles L 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CANDACE L WILSON ,mi 1500 FOREST GLEN RD SILVER SPRING NO

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ TRINIDAD GONZALEZ 1657 PM 2010 January Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY WATHINGTON ADVENTIST ITOSPITAL TAKOMA PARK If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Hours Feb. 26, EI Salvador 552-29-5369 59 Director โ′950 Usual Residence of Decedent of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c, City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland Prince Georges Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20783 8020 New Riggs Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2X No Baltimore, Maryland 21215-0036 1 XYes 2 No Specify: Salvadorian Specify: 3 Widowed 4 Noivorced White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) University Of Marylan [Custodian Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ၉ Maria Hernandez Felipe Chavarria Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8020 New Riggs Rd. Hyattsville, Maryland 20783 Maria White (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD. Nat. Mem. Park permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Feb. 5, 2010 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland Signal of Funeral Service License 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, Maryland 20706 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset an Death ONE GU infarction mmediate Cause (Final Myocardial Physician disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending hours are also as a second of the funeral Director. been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus, 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown End-Stage Renal Disease on hemodialysis Mitral Value Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 1 Yes 2 No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending **X**Natural work' 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29c. License number **D6** (007 29b. Signature MD January 29, 2010

State Registrar 12520 Prosperity Drive #320

Silver Spring, MD 20904

30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

32. Registras Signa

KENNETH KHANDAGLE

31. Date filed (Month, Day, Yea,

FEB 0 4 2010

State of Maryland / Department of Health and Mental Hygiene 2 [] | [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GRECO Day OF 20 HENRY ATRICK OI 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 D F Months Days Hours Mrd/22/1928 579-34-6904 81 Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No MD Anne Arundel Davidsonville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral 23a 3407 Davidsonville Rd. 21035 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after death Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ò þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: If Yes, Give White "natural", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry of Health and Mental Hygiene. item 27 is marked other than "other traumatic event, the Mer Elementary/Seconday (0-12) College (1-4 or 5+) Archivist US Gov't Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve မ Patrick Greco Louise Rosati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Greco Wife 3406 Hazelwood Rd. Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Atlantic Crematory 2/2/2010 4 Donation 5 Other (Specify) Glen Burnie, MD 22. Name and Address of FacilityHardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 17 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disc se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final te on chrone Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 🗌 No Yes 2 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 21438 Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNAPOLIS J. Lalentum DERENSE HIGHWA 445 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records.

of Vital

Division

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Amend Item 3 per hosp, 2900,02/18/2010dhb

1- For Amend Items 27,29c per dr., g900,02/09/10dhb | Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death January 03, Day 2010 **Physician** ALLEN GRAY, JR. 1813 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner dreverly Prince Georges' Prince Georges' Hospital Center If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 12/13/1975 9. Birthplace (State or Foreign Funeral **№** M 2 F 34 577-02-1869 Yrs Director Washington, D.C. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "naturel", or Iteme 23s or 28s-f show the Medical Examinar must be notified at Capitol Heights Yes 2 No MD PG**Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6500 Ronald Road 20743 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Never Married 2☐ Married 1 ☐ Yes 25 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 🖾 No Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Worker Private 12th permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Itam 27 is marked oth any linjury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Allen Gray, Sr. Margaret Graham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6500 Ronald Road; Capittol, Heights, MD Margaret Gray - Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/14/2010 Chesapeake Crematory Beltsville, Maryland 22. Name and Address of Facility Freeman Funeral Services 21. Signature of Funeral Service Licensee Part 1. Exter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line. 4594 Beech Road; Temple Hills, Maryland 20748 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician neumonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, transport of the cause. Enter Underlying Cause, Oisease or injury that initiated events as a consequence of): The law requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1X Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? tncephalopathi 3 ☐ Probably 4 ☑Unknown 1 ☐ Yes 2 ☐ No iabetes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed/ this certificete 2 No 2 No 1 Yes Division of Vital : After this certifice funeral director, p or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Certification: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ EF Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours efter death.

To the Funaral Director: A completely filled in by the fu investigation 1 Yes 2 No 2 Accident Gould not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Meyalidons D59556 110 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Landover heverly Rd 31. Date filed (Month, Day, Year) 32/Registrar's Signature State Registrar FEB 0 9 2010

Please Type or Print in Flack Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month HURST AURA **Physician** 30 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, **Examiner** Annapolitan Assisted Living Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 T 51 Massachusetts July 26, 1958 Director 212-80-3036 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location show ral", or items 23a or 28a-f shov 1 ☐ Yes 2 No Director Queen Annes Maryland Queenstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 21658 USA 205 Grason Vista Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 💥 No 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. δ Specify: 3 ☐ Widowed 4 ☑ Divorced White "natural" Be Completed th and Mental Hygiene.
7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Retail Sales Manager Macy's 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maureen Pritchard David Weber Henning 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Heath ar
Important: If item 27 is
any injury or other trau 205 Grason Vista Drive, Queenstown, MD 21658 Jane Marie Henning-sister 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Memorial Gardens Feb. 13,2010 Davidsonville, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility
Fleck Funeral Home, INC. MO1234 7601 Sandy Spring Rd., Laurel, MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death BRAIN Immediate Cause (Final Physician disease or condition resulting in death) / /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) cate has been signed by the page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2. No 2 No 1 ☐ Yes The MINION THE PAN completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1☐ Yes 2☐ No Hospital: 6 Other (Specify) ALF 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐No s after death. 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 2 and manner stated. 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number to completed cause of death (Item 23a) (Type, Print) Name and address of person

DHMH 17 Rev 1/2001

State Registrar MICHAEL

31. Date filed (Month, Day, Year)

JAN 2 9 2010

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32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 () State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1/26/2010 Physician/ Carlyle Everett Hawkins 8:17pmM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 447 Bendale Dr. Severna Park Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) DC Davs Hours 376/1937 Director 217-32-3951 72 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Yes XX No Anne Arundel Severna Park 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 447 Bendale Drive 21146 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married Married Completed by TXXYes If Yes, Give 2 No 1955 Baltimore, Maryland 21215-0036 1 ☐ Yes 2xx No Specify: White 3 Widowed 4 Divorced 1957 Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 10 Fed Gov't <u>Supervisor</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Clarence Hawkins Louise Perry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Hawkins Wife 447 Bendale Drive Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 20a Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2XX Cremation 3 Removal from State 1/28/2010 Glen Burnie , MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 70 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown the 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No injury Accident Investigation within 24 hours after death To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W 300 Annapolis 31 Date filed (Mont. 32. Registrar's Signature State 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 26,2010^{ar} Roy O. Hays 3AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Spa Creek Center Annapolis Anne Arundel If Under 1 Year 5. Social Security Number Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD 1 ₹ M 2 □ F Months Hours May 5,1918 91 Director 214-05-1971 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentai Hygiene.
Important: If firem 27 is marked other than "natural" or item on the trainment. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Anne Arundel Galesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20765 1017 East Benning RD. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2X No Specify: White WWII If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Superintendent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Maysia Kirk Oscar G. Havs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace Hays Spouse 1017 East Benning Rd. Galesville, MD 20765 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) ™ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Memorial 1/29/2010 Davidsonville, MD 21. Signature of Funeral Service Lie 22. Name and Address of Facility 12 Ridgely Ave. Hardesty Funeral Home P.A. Date Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician. disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Unknown 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed' After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 4 Aursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 \sum Yes 2 \square No Accident
Suicide Investigation 6 Could not be within 24 hours after death

To the Funeral Director. /
completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ecritiving Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

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State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31, Date filed (Month

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Funeral		Social Security Number 6. Security Number	7.7 M 2[X F		last birthday)	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 8. Date of		9		(State or Foreign
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altimore, mit. Pages 1 ar partment of Hea portant: If Item y injury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	lemoval from Sta	te c	emetery, cren	sition (Name of natory or other pla	сө) Ј	Jan. 26		Location - Ci		
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DIVISION Of VIţa Votte Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: Atter this certific completely tilled in by the funeral director.	ertification	3 Suicide 6 Could not be determined	28e. Place of building,	fnjury - At ho etc. (Specif	ome, farm, stre	eet, factory, office			on (Street Town, St	and Number ate)	or Rural Ro	ute Number,
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To th Compl	Me	29b. Signature and title of certifier		0		29c. Licens	se number	0.1	29d. [Date signed (Month, Day,	Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Paulette Janine Hall January 23, 2010 10:05 am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mariner Health Bethesda Montgomery Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Feb. 19^{Year)}1920 9. Birthplace (State or Foreign Country) France **Funeral** 1 🗆 M 2 🏝 F Months Days Hours 215-82-9078 89 Yrs Director Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🏝 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5721 Grosvenor Lane 20814 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married Yes 2 XNo If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: White "natural" 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Paul Vimond Marie Boulicault 19a. Informant's Name/Relationship *(Type, Print)* Joelle Rice/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 Tanglewood Court, Palm Coast, FL 32137 20a. Method of Disposition 20b. Place of Disposition (Name of Jan 25, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 🗌 Remova State Metropolitan Crematory Alexandria, Virginia 4 Donation Other (Specify) Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Signature 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Severe Rheumatoid Arthritis Physician/Medical Examiner To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran

Physician/ Medical **Examiner**

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Medical Certificate: To Be Completed by

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

Ve the Funeral Director: After this certificate

Division of Vital Records, P.O. Box 68760

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resulting in death)	Due to (or as a consequence of):				
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IF FEMALE:	d				
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Part II. Other significant conditions	contributing to death but not resulting in the under	lying cause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
Dementia, Depres	ssion, Hypertension		1 🗆 '	Yes 2 □ No 3 □ F	Probably 4 🖺 Unknown
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25. Was case referred to medical examiner?		26. Place of Death (Chec	k only one)		
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27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not	911	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe h	ow injury occurred	
4 Homicide determined	280 Place of Injury At home form street t	actory, office	28f. Location (S City or Tow	street and Number or Ru n, State)	ral Route Number,
(Check 2 Medical Exar	ysician: To the best of my knowledge, death occu niner: On the basis of examination and/or investigati irse Practioner: To the best of my knowledge, death	on, in my opinion, death occurred a	t the time, date a	nd place, and due to the	cause(s) and manner stated.
29b. Signature and title of certifier	3 1/1-	29c. License number D43121		29d. Date signed (Mont. January	h, Day, Year) 7 25, 2010

State

Registrar

31. Date filed (Month, Day, Year)

JAN 26

2010

rack

30. Name and address of person who completed clause of Castolite 230 (Type Print) Drive, Burtonsville, MD 20866

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State
 Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month February Day 2, 20°10 Kathryn Coolidge Huber 6:15 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Montgomery Bethesda 8. Date of Birth (Month, Day, Ye Jan. 26, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** Year) 1947 Days New York 1 □ M 2 □**x**F Hours 523-60-6823 63 Director Yrs Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must he notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b, County Director Maryland Montgomery Kensington 1 🗌 Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4029 Franklin Street 20895 **IISA** 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married by 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawrence David Coolidge Elizabeth Jane Ferguson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4029 Franklin Street, Kensington, MD 20895 John James Huber/Husband 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 2, Feb. 2010 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22, Name and Address of Facility
Francis J. Collins Funeral Home Inc
500 University Blvd. W., Silver Spr MD 2090 Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Multiple Cerebrovascular Accidents Medical Due to (or as a consequence of) **Examiner** Septic Shock 6 days Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Peritonitis that initiated events Due to (or as a consequence of): resulting in death) Last Diverticulitis 48 hours Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Marfan's Syndrome Completed Be မ Certificate:

 Hospital or Attending Physician: The law requires that the death certificate be executed
At hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and
eled filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760 To the Hospital or within 24 hours aff To the Funeral Di completed filled in

- Harran S Synars		LAN Yes 2 L	□ No 3 □ Probably 4 □ Officion			
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	
25. Was case referred to medical			26. Place of Death (Che	eck only one)		
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 X Inpatient 2	☐ ER/Outpatient 3 ☐	Home 5 Residence 6 Other (Specify)			
27. Manner of Death 1 🔀 Natural 5 🗌 Pending 2 🔲 Accident Investigation						
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined			28f. Location (Street and Number or Rural Route Number, City or Town, State)			

only on 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D42181

Certifying Nurse Practioner the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)

February 2, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Enrique Daza, MD 6420 Rockledge Drive, Bethesda, MD 20817

State Registrar

Medical

29a. Certifier

(Check

5

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 31. Date filed (Month, De Year)

32. Régistrar's Signature

10-00712 Su Cha Ho Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ı Cha Ho		State of Maryland / Departmen 1-For State Certificate		and Ment	tal Hyg		201	0 0424	
Physician/		1. Decedent's Name (First, Middle,Last)		=		Date of Dear	Day Year	3. Time of Death	
edical Examiner		Su Cha Ho 4a. Facility Name (if not institution, give street and number)	4b. City, Town	or Location o		January 2	4, 2010 4c. County of E	1752 hrs	
		2913 Chapel View Drive	Silver Sp				Montgome		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 5.79 - 0.4 - 6.9 1.8 1		Year If Under Days Hours			E	Birthplace (State or oreign	
Director		5 / 9 - 0 4 - 6 9 ! 8 1 M 2 X F 4 9 Usual Residence of Decedent	Yrs.			1/02/	1961	countinorea	
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygorne. teath and Mental Hygorne. traumatic event, the Medical Examiner must be notified at once.		10a. State 10b. County 10c. City, Town or L						10d. Inside City Limits	
	ţ	3	Spring					1 Yes 2 No	
	Completed by Funeral Director	10e. Street and Number 2913 Chapel View Drive	10f. Zip Cod	e 20904		1	Og. Citizen of What USA	Country?	
		11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of	Hispanic Origi			14. Race - A	merican Indian, Black,	
r death or iter		1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cul		Puerto Rio	an, etc.)		asian	
urs afte tural", amine			Yes 2X edent's Usual Occu	pation (Give k			Specify: 16b. Kind of Busin	ess/Industry	
6 n 72 ho an "na ical Ex		Elementary/Secondary (0-12) College (1-4 or 5+)	ng most of working Homemake		use retired)	Own	Home	
-003 d withii giene. ther th		17. Father's Name (First, Middle, Last)			s Name (Fi	rst. Middle. N	Maiden Surname)		
21215-0036 Uil be filed within 72 hours after all Hold Hygiene. marked other than "natural", it event, the Medical Examiner.	Be C	Sung Bak Hong		Hee Sook Han					
D 27 should and Me 7 is ma	To	19a. Informant's Name/Relationship (Type, Print) Pong Hwa Ho/Husband 29	ailing Address (St	treet and Numb	per or Rura	Route Num	ber, City or Town, S lver Sp	State, Zip C219904	
e, M 1 and 2 Health item 2		20a. Method of Disposition 20b. Place of Di	sposition (Name of			ate	20c. Location - Cit		
MOF Pages nent of ant: If		1 Burial 2 Cremation 3 Removal from State Chesap	or other place) eake Cr	em.	1/29	/2010	Beltsvi	ille,Md	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiera. Important: If item 27 is marked other than injury or other traumatic event, the Medica	21. Signature of Funeral Service Censee PHILIP D. RINALDI FUNERAL SERVICE 9241 Columbia Blvd.Silver Spring							ICE, P.A.	
Physician	Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximately 1997.							Approximate Interval	
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Hanging						Between Onset and Death	
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.							
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause							
ed 1sit	Ξxaπ	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
Box 68760, death certificate be executed he attending physician and of for use as the burial - transit	edical Examiner	d. UNPENDED AMENDED			_				
760, icate be physic the bur		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the					23d. Date of del	ivery	
Box 6876 he death certificate the attending phy hed for use as the b	ician	past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pre					ancy Month Day Year		
Bo. he deat y the at thed for	Perwall: 23b. Was decedent pregnant in the past 12 months? 1							to the course of death?	
Division of Vital Records, P.O. I To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by it completely filled in by the funeral director, page 2 should be detached.	by	Takin Other significant containers Community to death but not resulting in	ne underlying caus	se given in Fan	ι.		_	Probably 4 Unknown	
rds,	lete					24a. Was a		e autopsy findings available to completion of cause of	
Reco The lav cate has	Completed					perfor			
ital Fician:	Be	25. Was case referred to medical examiner? Hospital: Inpatient 2 ER/Outpal		other					
n of V Jing Phys After thi funeral di	ı: To	1 V Yes 2 No 28a. Date of Injury 28b. Time		njury at Work?		d. Describe h	Residence 6 🗸 0 ow injury occurred	trier: Scene	
ion ttendin leath. tor: A	atior	1 Natural 5 Pending FOUND Jan 24, 2010 FOUND 1737 hrs	1 1	Yes 2	No Su	bject hang	ged herself		
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Ru or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 2913 Chapel View Drive, Silver Spr							
Division To the Hospital or Attency, within 24 hours after death The the Funeral Director: completely filled in by the		4 Homicide (Specify) At home 2913 Chapel View Drive, Silver Spring, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To the within to comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
5	2	29b. Signature and title of certifier		ense number C.M.E.			January 25, 2		
		30. Name and address of person who completed cause of death (Item 23a)							
	Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
St Regist	tate	31. Date filed (Month, Day, Year) 32 Registrar's Signature	wed.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-00702 Timothy Curtis Haskell State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Registrar
Physician/ 1. Decedent's Name (First, Middle, Last) Reg. No. 2. Date of Death Month 3. Time of Death Day 1202 hrs

weulcal Examine	Timothy Curtis Haskell	January 24						
	4a. Facilify Name (if not institution, give street and number) 9949 Cherry Tree Lane	4b. City, Town, or Location of Death Silver Spring	4c. County of Death Montgomery					
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 215-42-9736 1XM 2F 64	Months Days Hours Min	h(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Texas					
and show any nce.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation	10d. Inside City Limits 1 Yes 2 X No					
he Maryls or 28a-f ified at o	10e. Street and Number	10f. Zip Code	og Citizen of What Country? nited States					
er death with ti	11. Marital Status 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No	Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.					
ours after itural", o	or Dates:	1 Yes 2 No specify: sedent's Usual Occupation (Give kind of work done	Specify: Caucasian 16b. Kind of Business/Industry					
215-0036 be filed within 72 hours afth ntal Hygiene. rked other than "natural" ent, the Medical Examine Be Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Adv	ing most of working life. DO NOT use retired)	Advertising					
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Curt Haskell	18.Mother's Name (First, Middle, M Eileen Spear						
mnd 24 and 2 should lealth and Me tem 27 is man traumatic every	Dana Rixter, Daughter 313	Mailing Address (Street and Number or Rural Route Num Barnard Court, Fairfax,	VA 22031					
Baltimore, MD 2 permit Pages I and 2 shoul perment of Heath and N Department of Heath and N Important: If item 27 is re injury or other traumatic	1 Burial 2 Cremation 3 Removal from State crematory	isposition (Name of cemetery, or other place) ic Crematory Date JAN. 28, 2010	20c. Location - City or Town, State Glen Burnie, Maryland					
Baltin permit. Departm Imports injury o	21. Signature of Funeral Service Licensee **Rrun M 7hr M01508	22. Name and Address of Facility Thibadeau Mortuary Servic 7 Park Avenue, Gaithersbu	e, P.A.					
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enfailure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerotic C	nter the mode of dying, such as cardiac or respiratory arre	Approximate Interval Between Onset and Death					
Examiner	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.							
red nsit Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):							
760, ficate be executed gphysician and the burial - transit								
cath certile attending for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5	Fetal death 3 Ectopic pregnancy Other (Specify)	23d. Date of delivery Month Day Year					
P.O. B es that the d igned by the detached	Part II. Other significant conditions contributing to death but not resulting in Diabetes Mellitus	the underlying cause given in Part I. 23e. Did tol 1 Yes	bacco use contribute to the cause of death? 2 No 3 Probably 4 ✓ Unknown					
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by P		24a. Was a autops perform 1 🗸 Yes 2	prior to completion of cause of death?					
Vital F ysician: ' his certific director, 1	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	26.Place of Death (Check only one) atient 3 DOA Other Nursing Home 5 1	Residence 6 🗸 Other: Scene					
con of Vision of the function	27 Manner of Death 128a Date of Injury 28h Tim	e of Injury 28c. Injury at Work? 28d. Describe h	ow injury occurred					
Division of N Hospital or Attending Ph 24 hours after death. Funeral Director: After tetty filled in by the funeral	3 Suicide 6 Could not be determined (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
To the Hospital within 24 hours To the Funeral completely filled	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. One) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) January 25, 2010					
	30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn S	Street, Baltimore, MD 21201						
State Registra	31. Date filed (North, Dg., Year) 2010 39. Registrar's Signature	ales						

Registrar DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 23, 2010 5:26a. Jimmy Leon Hamby Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Jan 26, 5. Social Security Number 6. Sav 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 ... F 58 South Carolina ີ່ 1951 Director 217-56-1639 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Maryland Frederick Frederick 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21703 **USA** 5824 Hannover Terrace death 1 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. or i 1 Never Married 2 Married Completed by 1 Yes 2 XNo within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: white 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Pastor Religion injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clara Williams Norman Luther Hamby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Hamby - wife 1 and 2 s of Health a item 27 i 21703 5824 Hannover Terrace, Frederick, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Olivet Cemetery 20c. Location - City or Town, State Date permit. Page 1 a Department of I Important: If ite any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 1-27-2010 Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final Hours Retroperitoneal Hemorrhage Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of, the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

The Euneral Director After this certificate has been signed by the attending physician and ripleted filled in by the invertal director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Year Day Pregnant at time of death 1 Yes 2L 9 Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 🗌 Yes 2 **(21)**0 ပ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c, Injury at work? 1 Yes Certificate: Natural 28d. Describe how injury occurred 5 Pending iniury 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1/23/2010 MD 51610 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Taney Avenue, Frederick, Maryland Michael Tolino 1474 31. Date filed (Month, Day Year)

State

Registrar

arka

32. Registrar's Signature

RAZERAGE

Registrar

Barke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Anse Hecter 2010 /Medical 4a. Facility Name (If no institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/29/1930 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1**⊠** M 2□ F 246-34-0942 79 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mydical Examiner must be notified at once. 1 ☐Yes 2 XNo Director Ellicott City Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9842 Michaels Way 21043 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1X Yes 2 No 1951-1 Never Married 2XMarried Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify Specify: ģ 3 Widowed 4 Divorced 1953 White Completed 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chemist Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Ansel Hester, Sr. Mary Heilig 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ruth Ann Hester / Wife 9842 Michaels Way, Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Ardent Cremation 1/28/2010 Hanover, MD 4 Donation 5 Other (Opecify) 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. M01411 21. Signature of Fundral Service Licensee 4112 Old Columbia Pike, Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** nera evere disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of) ending physician use as the burial Box 68760, that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. this certificate has been signed by the al director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred after death.

Director: After I bire to a the funera After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.P. D0066 SIF Jan 27 2010

Registrar
DHMH 17 Rev 1/2001

State

5755 Cedar Ln., Columbia, MD 21044

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

32. Registrar's Signature

ishi

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 6 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 28 s Jan. 2010 \mathbf{P}^{M} Evelyn Henson 4:14 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Sanctuary At Holy Cross Montgomery Burtonsville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Nov • I Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🕱 Months Days 86 **Director** 579-20-6325 DC Usual Residence of Decedent 28a-f shov 10b. County 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery 1 X Yes 2 No Burtonsville 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 3415 Greencastle Road 20866 United States Was Deceuc Armed Forces? Ves 2 X No 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Completed 3 XWidowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Elevator Operator Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clem Williams Laura Worthy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Smith Glenn/Granddaughter 5713 Sir Galahad Road Glen Dale, Maryland 20769 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State February Harmony Memorial 4 ☐ Donation 5 ☐ Other (Specify) Landover, Maryland 2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. Washington, DC 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months
1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? performed' 2 🗌 No Yes 2 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 📑 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manne eath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending М 1 Yes 2 No Accident Investigation neral Director: 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) i 24 hours after o e Funeral Direct determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Leonard Henninger Eugene January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Crofton Care and Rehab Center Crofton Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth **Funeral** 1 🖾 M 2 🗆 F Days (Month, Day, Year, 08/10/19) Months Hours Pennsylvania 191-14-5329 88 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Director MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13000 Midsummer Lane 20715 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces' 1 Never Married 2 Married 2 No Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates:1942-45 3 XWidowed 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) J Mental Hygiene. marked other than "r permit. Page 1 and 2 should be filed within : Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Installer Carpet and Tile Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Florence Schraeder Lester Henninger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris A. Torosian/Daughter 12720 Quarterhorse Drive, Bowie, MD 20720 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation_5 ☐ Other (Specify) Resurrection Cemetery 01/29/2010 Clinton, Maryland 21. Signature of uneral Service Licensee 22. Name and Address of Facility Beall Funeral Home P 6512 NW Crain Hwy. . Bowie. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examin death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Medical Box 68760 as the t IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death Physician/ 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Month Pregnant at time of death g Unknown or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No of Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Division 1 🗌 Yes 2 🗌 No within 24 hours after death. To the Funeral Director: A completed filled in by the fu Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time

7:20

9. Birthplace (State or Foreign

White

Approximate erval Retween

Year

Christie

10d. Inside City Limits

1 Yes 2 ☐ No

Αм

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3/Day Physician/ WiDD PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3615 Mabank Lane Prince George's Bowie 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** , 1930 Washington, D.C 1 **M**M 2 □ F Months Mar. 23 578-34-9057 **Director** 79 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Prince George's Bowie 1

✓ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3615 Mabank Lane 20715 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 0 Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", If Yes. Give Specify: White 3 Widowed 4 Divorced Year or Dates the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) h and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Firefighter Firefighting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Thomas Otis Hunter Virtie Katherine Higgs and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Margaret Hunter / spouse 3615 Mabank Lane Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State Page 1 1 🗆 Burial 2 🗓 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 2/2/2010 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 23a. Part 1. Enter the disease, or complications that caused shock, or head failure. List only one cause on ach line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 3 Miss Medical resulting in death) Due to (or as a co equence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or impury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burlal-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical P.O. Box 68760 signed by the attending d be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 L Yes 2 L 9 Dunknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 2 🗌 No Yes 1 🗌 Yes Division of Vital 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 MResidence 6 Other (Specify, 1 Yes 2 Vo ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manger of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 🗆 Yes 2 🗆 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, de ath occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed dause of death (Item 23a) (Type, Pri L State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day → Month Vear 820 PM ROYCE DEAN HAWLE an. 2010 28 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death HOWARD COLUMBIA MOSPITAL HOWARD COUNTY GENERAL If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year, 5/7/1934 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year) XXM 2 F 75 PA105-26-7720 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Howard Laure1 1 □Yes 2x No 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 20723 USA 8776 Susini Dr. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black White etc 1 XYes 2 No Korea
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 🗓 No Specify: Specify: **3€**Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Insurance Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elzen Henry Royce W. Hawley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1519 Arezzo Circle Boyton Beach, FL 33436 <u>Debra A. Hill</u> Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 24 Cremation 3 ☐ Removal from State 1/30/2010 Atlantic Crematory Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Euneral Service Hardesty Funeral Home, P.A. Doch 12 Ridgely Ave. Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HEPATOCELLULAR CARCINOMA Due to (or as a consequence of) HEPATITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duly to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 HInknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐ Yes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation

Physician /Medical Examiner law requires that the death certificate be executed

permit. Pages 1 and 2: Department of Health a Important: If item 27 is any injury or other trau

Physician

Examiner

Funeral

Director

28a-f show

MD

Director

Funeral

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Completed

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Physician/Medical

2

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Medical Certification:

traumatic event, the Medical Examinar must be notified at

1 and 2 should be filed within 72 hours after death with the I Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-

Maryland 21215-0036

Baltimore,

Box 68760,

P.0.

Records,

Division of Vital

/Medical

burial-tra attending physician for use as the buria ed by the detached signed by page 2 should peen has

certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a, Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

FEB 02

063242

110 S. PACA ST. 2ND FLOOR BALTIMINE MD 21201

Tan/28/2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHAH 31. Date filed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04255 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month WARI TANVIAR Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😾 F Months Hours 0472571921 Country) 169-16-5744 **Director** 88 Usual Residence of Decedent or 28a-f shov 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Tes 2 No MD Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 43 West McKinsey Road 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2X Married Completed by ☐ Yes 2 Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 04 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Anthony Morrone Rose Vigna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edwin Lee Howard Spouse 43 West McKinsey Road Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 20c. Location - City or Town, State 1 ☐ Burial 2 ☐XCremation 3 ☐ Removal from State 02/02/2010 Glen Burnie, MD 4 Donation 5 Other (Specify) Signature of Funeral 22 Name and Address of Facility 851 Annapolis Road Gambrills, MD 21054 Hardesty Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ONGOSTI Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last as the burialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Ectopic pregnancy Month Pregnant at time of death the g 🗌 Unknown g 🗌 Unknown P.O. | þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? this certificate 2 1 No the Hospital or Attending Physician: Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? WinZ 2 - No မ 1 Inpatient 2 I ER/Outpatient 3 -☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After (Month, Day, Year) Natural 5 Pending 1 🗌 Yes 2 No Accident Investigation Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the pasis or examination and/or investigation, in the opening, seal of control of the pasis of examination and/or investigation, in the opening of the pasis of examination and or investigation, in the opening of the pasis of examination and or investigation, in the opening of the pasis of examination and or investigation, in the opening of the pasis of examination and or investigation, in the opening of the pasis of examination and or investigation, in the opening of the pasis of examination and or investigation, in the opening of the pasis of examination and or investigation, in the opening of the pasis of examination and or investigation, in the opening of the pasis of examination and or investigation, in the opening of the pasis of examination and or investigation and or i only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause 31. Date filed (Month, Day, Year State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 04256 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Florence Louise Huszar January 30 /Medical 2010 8:45 A 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mallard Bay Care Center Cambridge Dorchester Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🕱 F Director 84 March 10 1925 Delaware 221-12-7915 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f st the Medical Exercities is ust be nutified Director 1 XYes 2 No MI Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 520 Glenburn Avenue 21613 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces? 1 □Yes 2 ☑ No 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify ģ Specify: white filed within 72 hours 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) garment line worker 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ont of Health and Mental It If item 27 Is marked of y or other traumatic ever Pages 1 and 2 should be 1 nent of Health and Mental Noble Conoway Viola Morris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Choptank Avenue, Cambridge, MD Philip J. Davis 21613 son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🗷 Removal from State Department of Important: If any Injury or once. Melson Cemetery 2/4/10 Delmar, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licenses 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) oral Concer **Physician** ieymina /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Erico poerning Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Vear Day ☐ Pregnant at time of death 5 Other (specify) I ☐ Yes 2 ☐ No 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 autopsy performed? Yes 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Box 68760. The law requires that the death certificate be P.0. Records. Vital Hospital or Attending Physician: filled in by the funeral dir of **Division** s after death.

Baltimore, Maryland 21215-0036

1 Yes 2 No 27, Manner of Death 1 ☑ Natural 2 Accident 3 ☐ Suicide

29a. Certifier

5 Pending investigation 6 ☐ Could not be determined 4 Homicide

29b. Signature and title of certifier

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work?

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 1 □ Yes 2 🗆 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Lecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

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2010

21613

NOMIAN RYRN MARNONY 503 31. Date filed (Month, Day, Year)

32. Re

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

CAMBRIDGE

State Registrar

Certification: To

Medical

24 hours

within 2

To the I

DHMH 17 Rev 1/2001

Registrar

Sara Lazzaro

10-00687

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene -UNK UNK

		1- For State Registrar Registrar Registrar	U4230							
Physic Medical Exan		1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Voc	3. Time of Death 1833 hrs							
b.		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Holy Cross Hospital 4c. County of Death Silver Spring Montgomery								
Funera Directo		5. Social Security Number 068–32–5254 6. Sex 1. Age (In yrs. last birthday) 1. Months Days Hours Min. July 2, 1927 Foreign Court								
y any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits							
ryland a-f shov t once.	횽	Maryland Montgomery Wheaton 10e, Street and Number 10f, Zip Code 10g, Citizen of What Coun	1 Yes 2 X No							
h the Ma 3a or 28 octified a	Director		uy:							
imore, MD 21215-0036 Pages I and 2 should be filled within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27; marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	Funeral	12. Was Decedent Ever in U.S. Armed Forces? Yes 2 No No specify: No specify: No specify: 12. Was Decedent Ever in U.S. Armed Forces? Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American White, etc. 15. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Yes, specify White								
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6 F E E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Restaurant Worker Restaurant								
Baltimore, MD 21215-0036 per nit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than injury or other traumatic event, the Medica	Be Cor	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown								
ID 21; should b and Men 7 is mar!	5	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Mary A. McFarland/Daughter 5610 Haddington Drive, Adamstown, MD 21710	Zip Code)							
ore, N ss 1 and 2 of Health If item 2		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or 1								
Iltimo nit. Page artment o		4 Donation 5 Other Specify: Gate of Heaven Cemetery 2010 Silver Sprin	g, Maryland							
		Tuckerd L Actes Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20								
Physician /Mrdical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries	Approximate Interval Between Onset and Death							
LXaIIIIIei		or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):								
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unique of the middled C.								
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Da 23d. Date of delivery Month Da	ay Year							
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ords, P w requires the been signed should be d	ted by	1 Yes 2 ✓ No 3 Proba	by 4 Unknown							
Division of Vital Records, P.O. ral or Attending Physician: The law requires that it as after death. **All processors** After this certificate has been signed by led in by the funeral director, page 2 should be detact	Completed	autopsy prior to co performed? 1 ✓ Yes 2 No 1 ✓ Yes	mpletion of cause of							
Vital Rec ysician: The his certificate director, page	BeC	25. Was case referred to medical examiner?								
of Vi g Physi fter this	유	1 Ves 2 No Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other:								
Sion Attendin death. cctor: A	catio	1 Natural 5 Pending Investigation Pending In								
DIVI Hospital or 24 hours after Funeral Directly filled in 1	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Georgia Ave & Shorefield Rd, Silver								
Division of 1 To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Medical (1 29a Centiter								
	Me	29b. Signature and Affile of certifier 29c. License number 29d. Date signed (Mont O.C.M.E. January 24, 2010	h, Day, Year)							
****		30. Name and add/ess of person who completed cause of death (Item 23a)								
OCME	tate	Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed Month, Day Year 22. Registrar's Signature								
Regis	trar									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 27, 2010 Physician 5:10A. M Rose Marie Ianni /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 3157 Gracefield Road,#HG210 Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Aug. 21, 1922 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛱 F Months Days Hours Min. 484-18-3988 87 IOWA" Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Nedical Examination will be notified at Maryland | Montgomery Silver Spring 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with 3157 Gracefield Road, #HG210 20904 United States Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 □Yes 2 No ρ Specify: Specify: 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Secretary University of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert J. Lee Marie Sinnott ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary C. Crawford -daughter 111 Periwinkle Court Greenbelt, Maryland 20770 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 2/2/2010 |Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 Months Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Colon Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 XNo 1 ☐ Yes 2 ☐ Xuo 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier 1 🛣 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and till 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mark Parkhurst, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904 Registrar's Signature barket

D24093

January 27, 2010

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month William Earl Jett Sr. January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 X M 2 - F Hours Min. (Month, Day, Director 212-46-2737 62 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location must be notified at Funeral Director MD St.Marv's Leonardtown ō 10e, Street end Numbe 10f. Zip Code 10q. Citizen of What Country? 23a 40560 Juniors Court 20650 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 9 Completed by 1 Never Married 2 Married ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify.White "natural", 3 Widowed 4 N Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Fisherman Waterman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bernice Sweeney Roy Jett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shment of Health a ant: If item 27 is William Jett Jr./Son 115 5th Street Lothian, Maryland 20711 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) **Huntt Crematory** Jan 27,2010 Waldorf, Maryland 21. Signature of Funeral Savicy Licensee 22. Name and Address of Facility Huntt Funeral Home MO1262 \$035 Old Washington Rd. Waldorf, Maryland 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury attending physician and for use as the burial-trant that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2/01/10 Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: Natural 2 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending n 24 hours after death. le Funeral Director; Af pleted filled in by the fu 1 Tyes 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier s of person who completed cause of death (Item 23a) (Type, Print) Point Lookout man/s

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

04260

 \mathbf{P}^{M}

12:45

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between

Onset and Death

Month

death? 1 Tyes 1 Yes 2 No

2010

Registrar DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Shanti Josh January 30, 7:25 A Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12503 Gould Road Wheaton Montgomery 8. Date of Birth (Month, Day, Year) 14, 1922 5. Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) If Under 24 Hrs 9. Birthplace (State or Foreign Funeral 1 □ M 2 🔏 F Days Hours Country)
India Director 577-82-9344 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event: the Medical Examples. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 12503 Gould Road 20906 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Asian Indian 3 👿 Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Nagina Bhatti Parsini Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Asha Datta/Daughter 2503 Gould Road, Wheaton, Maryland 20906 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) KX Burial 2 Cremation 3 Removal from Stat February 2, Other (Specify) Rockville, Maryland Parklawn Memorial Park 4 Donation 2010 22. Name and Address of Facility Francis J. Collins Funeral Home, 21. Signature of Funeral Ser 500 University Blvd., West, Silver Spring, Maryland 20901 23a. Part 1. Enter the dislase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Coronary Artery Disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of): that initiated events Due to (or as a consequence of): resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 1 ☐ Yes 2¾ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 😿 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ျ 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 😾 Residence 6 🗌 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending n 24 hours after death.

e Funeral Director: Affolieted filled in by the fur Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 💢 Certifying Physician: To the best of mycknowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tit of certifi 29c. License number D32417 February 1, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gilotra, M.D. 12016 Georgia Avenue, Wheaton, Maryland 20902 Rahul 31. Date filed (Month, Pay, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sandra Jean JAFFE Physician/ $J_{anuary}^{Monthary} 26^{\circ}, 2010^{\circ}$ 10:30 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 01 ney Montgomery Montgomery General Hospital If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth Funeral 1 DM 2 X F Months Days Hours June 10, 1948 Minnesota 220-54-1761 Yrs. Director 61 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f sho dical Examiner must be notified at within 72 hours after death with the Maryland Director Silver Spring Maryland Montgomery 1 🗆 Yes 2 🎾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 United States 4 Broomall Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No 1 Never Married 2 Married 1 Yes 2X If Yes, Give Year or Dates. Specify: White ò 1 ☐ Yes 2 Ϊ No Specify: 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Special Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o ပ Sally Berkovitz Arthur Jaffe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11628 Log Jump Terrace, Ellicott City, MD 21042 19a. Informant's Name/Relationship (Type, Print) Bruce Jaffe, Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ₹ 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) King David Memorial Garden 01/28/10 Falls Church, VA 21. Signature of Funeral Service Licensee MU Torchinsky Hebrew Funeral Home 254 Carroll St. NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Demento 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 2 🗌 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 - No declined မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Med & and address of person who completed cause of death (Item 23a) (Type, Print) Tree 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Maryland 21215-0036

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Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 28, 2010 Eleanor R. Jones January 5:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days 1 □ M 2 🖾 F Director 89 03/22/1920 559-34-0518 California Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show r items 23a or 28a-f shined Director 1 ☐ Yes 2 X No Montgomery Village Maryland Montgomery the I 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 and Injury or other traumatic event, the Medical Examiner must be nonce. 20886 United States 19355 Dunbridge Way by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc 1 Never Married 2 Married ☐Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 □ No Specify: 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 College Librarian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David Embody Mary Finnigan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19355 Dunbridge Way Montgomery Village, MD. 20886 Charles Sicard (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 🙀 Removal from State Holy Cross Cemetery 4 Donation 5 Dother (Specify) 2010 Colma, California 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Lie see 10 East Deer Park Drive Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Days Acute Myocardial Infarction /Medical Due to (or as a consequence of) Examiner Coronary Artery Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit Years Type II Diabetes that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a Id be detached for ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown s been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 ☐Yes 2 🖾 No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 ∑XNo မှ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) D31391 January 28, 2010

Registrar

State

604 South Frederick Ave. #413 Gaithersburg, MD. 20877

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Suhair Abulfarag M.D.

JAN 29 2010

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Benjamin Jaffe 3:20 a M January Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Layhill Manor Montgomery Silver Spring 5. Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 912 Washington, DC 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Hours Director 578-18-8885 97 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2845 Blue Spruce Lane 20906 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 🔀 Yes 2 🗌 No If Yes, Give 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 2 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. "natural", 3 X Widowed 4 □ Divorced Completed WW I I Caucasian Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Taxi Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pe Louis Jaffe Bessie Unknown age 1 and 2 should bent of Health and Merit If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3713 Milbranch Place, Richmond, Virginia 23233 Sandra Corbett - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Lebanon Cemetery 01/28/2010 | Adelphi, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. <u> 11800 New</u> Hampshire Ave., Silver Spring, MD20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MONTHS Immediate Cause (Final Physician/ Failure to Thrive disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Dementia Years equentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗶 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death.

eral Director: After this certificate has filled in by the funeral director, page 2.9 performed' Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 🗓 No Other: Assisted ဂ္ 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funel completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and due to the cause(s) and manner stated.

Genifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 0+1 January 27, 2010 30. Name and address of per son who completed cause of death (Item 23a) (Type, Print) Nakul Goyal, M.D. 3801 International Dr., Suite 211, Silver Spring, MD 20906 31. Date filed (Month, Day, Year)

JAN 29 State 2010 backet Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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Examir		4a. Facility Name (if	1 0	ve street and number)	Alask		4b. City, Tow	vn, or L	ocation of Death	101)	4c. County	of Death	0.500
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp	osition	Removal from State	_	lace of Disp	position (Name o	f		Date	20c.	Location -	City or 1	Town, State
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the bur	Cert	4 Homicide	determine		ury - At ho c. (Specify,	me, farm, s)	treet, factory, off	fice		28f. Location (City or To			er or Rura	al Route Number,
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4/0		Ali Saher	1 100	E. Carroll	5+.	SAIS	oury, m	od,	21801					
Sta Registr		31. Date filed (Month	JAN 2 9 :	E. Carrell: 2010 32. Fegistra	ar's Signat	ure.	back							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amended#16a perState et Maryland & Department of Health and Mental Hygiene 2 Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARY 24, CONLON LAURA 39 PM JAMISON Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** ^{ar)}1918 1 □ M 2 🕱 F 91 Months Days Hours Min. 579-18-2425 **Director** WASH Usual Residence of Decedent 28a-f show 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits FREDERICK ADAMSTOWN MD 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21710 USA be filed within 72 hours after death with 3200 BAKERS CIRCLE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗵 No Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify: If Yes, Give 3 ₩ Widowed 4 □ Divorced Specify: WHITE Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life, DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) REALTOR REALOR REAL ESTATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 LAURA WESSELLS THOMAS A. CONLON prmit. Page 1 and 2 should be spartment of Health and Men sportant: If item 27 is marke y injury or other traumatic. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AIMEE JAMISON / DAUGHTER 17416 FOUNDERS MILL DR., ROCKVILLE, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1:
Department of I
Important: If it
any injury or or 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) CEMETERY 1/28/2010 MARYS BARNESVILLE, 21. Signature of Superal Service Lidenses 22. Name and Address of Facility
HILTON FUNERAL HOME N BOX 86, BARNESVILLE 20838 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Tabolit disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of) 16 Due to (or as a consequence of) resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 1 Yes 2 No Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2/X No Other: မှ 1 Yes Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 28d. Describe how injury occurred injury work? 5 Pending 2 No ieral Director: / filled in by the f Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 MDD 35106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 7th 21701 MYUNG HEE MD W. FREDERICK, MDNAM, 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav 7:45 P M Thelma Virginia Johnson Medical January 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 20320 Thunderhead Way Germantown Montgomery 8. Date of Birth
(Month, Day, Youne 30, Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Funeral Days Hours ^{Year)} 19<u>27</u> Maryland 1 🗆 M 2🗶 F Director 82 217-24-6741 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery 1 Yes 2 No Germantown 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 20320 Thunderhead Way 20874 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: and Mental Hygiene. is marked other than "natural", Specify: Black Completed 3X Widowed 4 ☐ Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 **Homemaker** Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph Dorsey Henry Esther Snowden 19a. Informant's Name/Relationship (Type, Print) Grand-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tanya L. Smith Sikharulidze/ permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 20320 Thunderhead Way Germantown, Maryland 20874 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 2/3/2010 Woodbine, Maryland 21. Signifure of Funeral Service 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Marita omas M00957 Beverly L. Heckrotte, P.A. 23a. Parv. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition CHRONIU 115mg Medical resulting in death) Due to (or as a consequence of) Examiner DIMERO Sequentiary flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Dav Pregnant at time of death signed by the a d be detached f q | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SCHIZERHMENTA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ASPIRADON PNEUMONIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas page performed? Yes 2 (No 2 🗌 No 1 Tes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: ည this (1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural М 1 Yes 2 No Accident Investigation after death the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Funeral L Medical 29a. Certifier 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

3416 OLAMBUNON COURT

20834

who completed cause of death (Item 23a) (Type, Print)

m

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 pe me, g901,0370372010dhb. Certificate of Death Reg. No. For State Registrar 2 Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** /Medical 4b. City Town, or Location of Death 4c. County of Death a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital **Baltimore City** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9/15/1960 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 F 49 230-17-0422 Japan Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10h County 10c. City, Town or Location 10a. State 28a-f show 1 ☐ Yes 2 No Examiner must be notified at Director MD Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 23a or 21043 Was Decedent Ever in U.S. Armed Forces? Japan Funeral 3617 Hollow Fields 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛂 No Baltimore, Maryland 21215-0036 Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced Asian "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Hygiene. other than Business Owner Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental H Shiqemasa Maeda Hideko Kawamata ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any injury or other traionce. 3617 Hollow Fields Ct. Ellicott City, MD 21043
of Disposition (Name of Date 20c. Location - City or Town, State Dong Gyun Jung / Husband 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1/29/2010 Ardent Cremation 4 Donation 5 Other (Specify) Hanover, MD 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Fureral Sovice Licenses 4112 Old Columbia Pike Ellicott City, MD 21043 M01411 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ntracerebra /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it is to be a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner Due to for as a consequence of The law requires that the death certificate be executed Due to (or as a consequence of) inding physician a r use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? Day Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 2 🗌 No 3 Probably 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe has 2 □ No 1 🗌 Yes certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Hospital 2 ER/Outpatient 3 DOA 1X Yes 2 [Inpatient 6 Other (Specify) Certification: To Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred funeral 28a Injury Director: After 5 Pending investigation Natural 1 Tes 2 🗌 No Accident completely filled in by the 3 Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide e Funeral Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) d) romas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Katherne Thomas,

JAN2

31. Date filed (Month, Day, Year)

MD

32. Registrar's Signature

DHMH 17 Rev 1/2001

Backer

600 North Wolfe St, Baltimore, MD, 21287

Fo AMEND#26 per PHY

1. Decedent's Name (First, Middle, Last)

Clifford Vincent Jackson

Physician

1 - State 2/1/2010 AACO HEALIH DEPT. CMH

SQUAMOUS CELL CANCER OF THE SKIN 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No -5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred Certification: 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by To the Hospital or within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier JAMUARY 26 2010 who completed cause of death (Item 23a) (Type, Print) 7325A HAMOVER PARKWAY GREENBELT MARYLANED 20770 31. Date filed (Month, Day, State FEB 01 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death January 25°ay

201(gar

9. Birthplace (State or Foreign

10d. Inside City Limits

1 XYes 2 No

PA

Country.

Black, White, etc.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARY 27, 2010 JAMES PHILLIP JOHNSON, III 10:42P.M , Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNE ARUNDEL ANNAPOLIS Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Funeral 8. Date of Birth 1 X M 2 D F Months Hours FEBRUARY 8, 1968 COMARYLAND 41 Yrs Director 002-62-4793 Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director be notified 1 Tes 2X No ANNE ARUNDEL MARYLAND GAMBRILLS 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? is 23a o. c must b Funeral 2407 SNOW HILL COURT 21054 UNITED STATES "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. by 1 X Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify. Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working INFORMATION Elementary/Seconday (0-12) College (1-4 or 5+) IT NETWORK ENGINEER TECHNOLOGY other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname i. Page 1 and 2 should be file tment of Health and Mental H tant: If item 27 is marked of jury or other traumatic ever 2 JAMES PHILLIP JOHNSON, JR. ANGELA DOVI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES PHILLIP JOHNSON, JR./FATHER 300 EATONS LANDING DRIVE, ANNAPOLIS, MARYLAND 21401 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of CHESAPEARE CREMATION CENTER JANUARY 29 2010 Department o Important: If any injury or 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MARYLAND 22. Name and Address of Facility FELLOWS, CREMATION AND FUNERAL CROAD, ANNAPOLIS, MARYLA HELFENBEIN AND NEWNAM ARE P.A., 814 BESTGATE D 21401 21. Signature of Funeral Service Licenses Well Esson M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to r as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ☐ Pregnant at time of death☐ Unknown 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed Yes 2 No death? this certificate 2 🗌 No 1 🗌 Yes or Attending Physician: 25. Was case referred to medical funeral director, Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer 1 Natural 5 Pending work 1 Tes 2 🗌 No

within 24 hours a

To the Funeral C

completed filled LD

Registrar

Medical

2 Accident
3 Suicide
4 Homicide

3

29b. Signature and title of certifier

29a. Certifier (Check

Investigation 6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Brint)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

egistrar's Signatur

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

El ste 300 Annapolis

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Certificate of State			201	0 06271
			Registrar 1. Decedent's Name (First, Middle, Last)	- Douth	2. Date of Dea		3. Time of Death
	Physicia /Medic		Ellen Knight		Januar	y 25 20	10 6:15 A M
	Examin			n, or Location of Death	1	4c. County of De	
			622 Tuckahoe Creek Ct. Anna 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yes	apolis ar If Under 24 Hrs.	8. Date of Birt		Arundel irthplace (State or Foreign
	Funeral Director		220-84-3912 1 M 2 F 47 Yrs. Months Day		July 2	y, Year) 20 1962	Maryland
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	/aryla	٥.	Maryland Anne Arundel Annapolis				1 ☐ Yes 2 ☑ No
	r 28a-	Directo	10e. Street and Number 10f. Zip Cod	e		10g. Citizen of What (
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36	hours after death with the Maryland tural", or items 23a or 28a-f show at Examinar nast be notified at	by F	1 Danier Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 Danier	Specify:		Specify: F	Black
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altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Machel Experiment is as the refilled at once.		20a. Method of Disposition 20b_IPlace of Disposition (Name of Cemetery, crematory or other)	olace)	Date	20c. Location - City	
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	/Medical Examiner		resulting in death) Due to (or as a consequence of):	V			0
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S	s beer shou	Completed			24a. Was		autopsy findings available
Ĕ	The la ate ha sage 2	Omp			autop perfo 1 □ Yes	rmed? death	
Vital Records,	clan: sertific setor, (Be	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only o	ne)	
10	Physical critical critical direction	<u>د</u>	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Ir	Other: 4 Nursing H	ome 5 Resid	dence 6 Other (S)	pecify)
0	th. : Afte	tion	1 Matural 5 Pending (Month, Day, Year) Injury V	njury at Vork? I ∐Yes 2 □ No	200. Describe i	low injury occurred	
VISION	r Atter er dea rector by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	ре	28f. Location (5 City or Tow	Street and Number or	Rural Route Number,
5	ital or urs aft ral Dir lled in						
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours attent death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the (Check only one) Medical Examiner: On the basis of examination and/or investigation, in manner stated.				
	To the within To the comple	Mec	29b. Signature and title of certifier 29c. Lice	ense number		29d. Date signed (Mo	nth, Day, Year)
	11.1		I allow (Xerro MD) Do	0048101		Januari	127,2010
	XH I		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Donna Chambers MD 133 Defense	Huy Sui	te 112	Annapoli	1 27, 2010 MD 21401
	Sta Registra		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Donna Chambers MD 133 Defense 31. Date filed (Month, Day, Year) JAN 28 2010 32. Registrar's Signature JAN 28 2010 Aparts	U			

1	_	For State Registra	r
4		annolomi'a	N.I.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

	<u></u>
Reg.	No.

Physician /Medical **Examiner**

Funeral Director

the Maryland la or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with items 23a "naturel", or its th and Mental Hygiene.
7 Is marked other than "natur traumatic event, the Medical. of Health a other t Jo

3altimore, Maryland 21215-0036

Box 68760.

P.0.

Division of Vital Records,

permit. Pages Department of Important: If It any Injury or o Physician /Medical Examiner

Examiner

Physician/Medical

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Completed

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Certification: To

Medical

law requires that the death certificate be executed physician and s the burial-trans attending p s been signed by the should be detached page 2 certificate funeral director, this death, al or Attend after death filled in by the within 24 hours a Hospital

Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month PAUL MERRILL KELLEY 2010 24 8:43 A JAN 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death MONTGOMERY ROCKVILLE SHADY GROVE ADVENTIST HOSPITAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 1 X M 2 □ F Months Days Hours 1930 WASH. MAR 3 577-44-0515 79 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 No Director MONTGOMERY GERMANTOWN MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 15904 GERMANTOWN ROAD 20874 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: WHITE þ 3 ☐ Widowed 4 ☑ Divorced Year or Dates:1955 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AUTO SUPPLY BUSINESS OWNER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CATHERINE MERRILL ပ္ THOMAS C. KELLEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20841 BOYDS, BOX 31, MD JUSTIN KELLEY SON P.O. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State STAUFFER CREMATORY 1/29/2010 FREDERICK, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, 20838 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MINUTES ACUTE MYOCARDIAL INFARCTION disease or condition resulting in death) Due to (or as a consequence of): YEARS CORONARY ARTERY DISEASE Signification of the cause of t Due to (or as a consequence of) YEARS HYPERTENSION Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No 1 ☐ Yes 2 ☐ No I∐Ÿes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ► ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JANUARY 24, 2010 64235 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

CENTER DR.,

ROCKVILLE,

MD 20850

9901

MEDICAL

32 Registrar's Signature

BUZY,

31. Date filed (Month, Day, Year)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State o	f Marylar		artment of F rtificate of i		Mental Hygi	iene 0 1 0	04273
	Physic		Decedent's Name (First, Midd MA IMA	le, Last)	KAIZOE	E			2. Date of Death Month		3. Time of Death
1	/Medi Examir		4a. Facility Name (If not institution		mber)		4b. City, Town, or LAUREI	r Location of Death		4c. County of Death PRINCE GE	
	Funeral Director		5. Social Security Number 578-25-6845	6. Sex 1 ☐ M 2 ■ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) Cour	place (State or Foreign htry) ERIA
	yland how at		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Loc	cation		DEC. 10		0d. Inside City Limits
	r 28a-f s notified	Director	MD PRINCI	E GEORGE'S	I	LAUREL	10f. Zip Code		10	g. Citizen of What Cour	1X☐Yes 2☐No
	ns 23a o must be	Funeral D	9116 BRIARCHII	12. Was Dece	edent Ever in U	S 13 V	20708	ispanic Origin? (Sr		USA 14. Race - Americ	ean Indian
5-0036	ours after o ral", or iter	þ	1 ☐ Never Married 2 ☐ Mar 3 ☒ Widowed 4 ☐ Divorced	ried Armed Fo	rces? 2 X No /e		Vas Decedent of H fYes, specify Cuba □Yes 2 No	Specify:	Rican, etc.)	Black, White,	
21215-(should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. S marked other than "natural", or items 23a or 28a-f show umatic event, I're Medical Examiner must be notified at	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed) College (1	-4or 5+)	(Give I	lent's Usual Occup kind of work done o OO NOT use retired WIFE	during most of work	ing 1	6b. Kind of Business/Ind	dustry
Maryland 2	e grapa	To Be Co	17. Father's Name (First, Middle, MOHAMMED BA)	*		<u> </u>			e (First, Middle, Mi KAIZOE	aiden Surname)	
Σ :	tra tra		19a. Informant's Name/Relations MATTHEW J. PU							City or Town, State, Zip	
baitimore,	permit. Pages 1 and Department of Heali Important: If item 2 any Injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State	emetery, crem	sition (Name of latory or other place	e) !	.	Oc. Location - City or To	
Balt	Departr Departr Importa any Inju		21. Signature of Funeral Service	Licensee		22.	Name and Addres	s of Facility J	B. JENK	INS FUNERAL R,MARYLAND	
P	hysician	e in	23a. Part 1. Enter the disease, or shock, or heart failure, List Immediate Cause (Final disease or condition	complications that ca only one cause on ea	ach line.	h. Do not ente	The mode of dying		or respiratory arres	st,	Approximate Interval Between Onset and Death
	/Medical xaminer		resulting in death)	Due to (or as nsequ						
potition	ansit	Examiner	Sequentially list conditions, If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (и ав а виненц						
8/6U,	nysician ar ne burial-tr	edical Exa	resulting in death) Last	Due to (d	or as a consequ	uence of):					
the death certifical	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 25□ No 9 □ Unknown		irth 2 🗍 Fetal ant at time of d	I death 3 □	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ory Day Year
COLOS, T	been signed by the should be detached	ρ	Part II. Other significant condition	ons contributing to de	ath but not resu	ulting in the und	derlying cause give	n in Part I.	1	acco use contribute to th	
	cate has be	Completed							24a. Was an autopsy performe 1 ☐ Yes 2 [prior to con death?	osy findings available npletion of cause of
N VILC	h. After this certificate h funeral director, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ဩt	npatient 2	ER/Outpatient	3 ☐ DOA Othe		(Check only one)	ce 6 ☐ Other (Specify	
ending P	ath. or: After t he funera	ation:	27. Manner of Death 1 ★ Natural 5 Pending 2 Accident investig	ation	f Injury n, Day, Year)	28b. Time of Injury	28c. Injury Work' M 1 □ Y	at	28d. Describe how		,
ital or Att	rs after de ral Direct	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ned 28e. Place	of Injury - At ho g, etc. <i>(Specif</i>)	me, farm, stree	et, factory, office		28f. Location (Stre City or Town,	et and Number or Rural State)	Route Number,
the Hosp	hin 24 hou the Fune npletely fil	Medical	one) Medical	examiner: On the ba	sis of examinat	wledge, death tion and/or inve	estigation, in my op	pinion, death occur	and due to the cau ed at the time, dat	use(s) and manner as st e and place, and due to	ated. the cause(s)
٩	wit To	2	29b. Signature and live of fertifier	MD			29c. License	number 06358		I. Date signed (Month, D	
7	3		30. Name and address of person MINA M. YACO	UB M.D. 13	310 SOU'	THERN A		E. WASHI	NGTON, DC	20032	
	Stat Registra		31. Date filed (Month, Day, Year) FEB 0 4 2010	Beneva)	gistrar's Signat	ure					

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		,	For State	State o	f Marylan		artment of H		and Me		giene,		04	274
			Registrar 1. Decedent's Name (First, Middle	e. Last)				Joann	2	2. Date of Dea			3. Time of	Death
	Physici		Robert E. Lock	, ,						Month January	Day	$20\overset{Year}{0}$	12:47	
	/Medic		4a. Facility Name (If not institution		mber)		4b. City, Town, or	Location of		, 411 441	1	ounty of Deat		
	LAGIIIII	ICI	Prince George'			2	Cheverly					nce Ge		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I		If Under 1 Year	If Under 2	24 Hrs. 8	3. Date of Birt	<u> </u>	9. Birt	hplace (State o	r Foreign
	Director		142-28-3224	1 🛣 M 2 🗆 F	72	Yrs.	Months Days	Hours	Min.	OEC 2	1937	Ohi	untry) `	
ы	> -		Usual Residence of Decedent 10a. State 10b. County		100 014	. Town and a							40d Inside Ci	
aryla	shor	7				, Town or Lo							10d. Inside Ci 1 XYes	
he M	28a-f	ect	DC 10e. Street and Number		Wash	ningto					40- Oilin	en of What Co		2010
d ZIZI3-UU36 filed within 72 hours after death with the Maryland	aor	Funeral Director		NE			10f. Zip Code				-		•	
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fter d	r Iten	Fur	1 □ Never Married 2 □ Marr	Armed Fo	rces?		Vas Decedent of H f Yes, specify Cuba	in, Mexican,	, Puerto Ri	ican, etc.)		Black, White	e, etc.	
urs a	al', o	by	3 Widowed 4 Divorced	If Yes, Gi	re UKN	1	I□Yes 2N□No	Specify:			5	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	rican erican	
1 3-0036 172 hours aff	call	Completed	15. Deceden	t's Education		16a. Deced	dent's Usual Occup	ation			16b. Kind	of Business/		
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and be file	d off	Be	17. Father's Name (First, Middle,	Last)					r's Name (i	First, Middle,	Maiden S	urna m e)		
y a	Men larke	ျှ	UKN					UKN						
Mar 2 sh	or heatin and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, if a Medical Exemple in mail be notified at		19a. Informant's Name/Relations	, , , ,		19b. Mailin	g Address <i>(Street a</i> Woodmont esda, MD	and Number	or or Rural I	Route Numbe Suite	r, City or 430	Town, State, 2	(ip Code)	
1 and	Healt Sm 27 ther 1		Brett E. Cohen 20a. Method of Disposition	, Guardia		Beth	esda, MD	20814	Dat					
Segr	or o		1 XBurial 2 ☐ Cremation		State		sition (Name of natory or other plac	į J.	AN. 2			ation - City or		_
rmit. Pages 1	njury		4 Donation 5 Other (S		Mt.		1 Cemete: Name and Addres	-	010		Balt	imore,	Maryla	nd
per D	Department of Health a Important: If item 27 Is any injury or other trainonce.		21. Signature of Funeral Service.	Mu	M009	_ T!	hibadeau	Mortu	ary S	Service	, p.	a.	-	
			23a. Part 1. Enter the disease, or	complications that c			Park Ave					D 2087	/ Approximate	9
-			shock, or heart failure. List Immediate Cause (Final	only one cause on e	ach line.		or the mode or dy iii	g, ouon uo c	our dido or i	roopiiato. y ai	.000,		Interval Bet Onset and I	ween Death
	/sician ledical		disease or condition resulting in death)	_ a	IC SHOCK								DAYS	
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The law requires that the death certificate be executed	physician and the burial-transit	dical		d										
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atho	or us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live l	come of pregnar pirth 2☐ Fetal	death 3	Ectopic pregnancy	/			23	d. Date of del Month		'ear
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an:	certificate ector, pag	Be C	25. Was case referred to medical					26. Place	of Death /	1 □Yes Check only o		1 LJYes	2 □X No	
ysic	.s :E	To B	examiner? 1 ⊟ Yes 2 ဩ-No	Hospital: 1 🔀	npatient 2 🗆 I	ER/Outpatien	t 3 DOA Othe					□Other (Spe	cifv)	
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endin	or: A	ätic	2 Accident investig	ation				Yes 2□N	No					
or Att	irect n by 1	Certification:	3 Suicide 6 Could r 4 Homicide determ	ned 286. Place	of Injury - At hor ng, etc. (Specify		eet, factory, office		28	f. Location (S City or Tow	treet and n, State)	Number or Ru	ıral Route Num	ber,
ire a	illed i		00 0 0 0											
Hos P4 Pc	To the Funeral Director: After completely filled in by the fun	edical	29a. Certifier 1 X CertifyIn (Check only one) 2 Medical	g Physician: To the Examiner: On the b	best of my know asis of examinat her stated.	viedge, deatr ion and/or inv	estigation, in my o	ne, date and pinion, deat	d place, an th occurred	d at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s	
o the	o the	Mec	29b. Signature and title of certifier	and man	iei stateu.		29c. License	number			29d. Date	signed (Montl	n, Day, Year)	
			· P	Jutroi	MD		D2472	0				ARY 17		
2			30. Name and address of person	0		23a) (Type I		<u> </u>			JANU.	ML 1/	, 2010	
			RAVINDER K. RU		,		,	, CHE	VERLY	7, MD 2	0785			
	Sta	_	31. Date filed (Month, Day, Year)	- CO D										
	Registra	ar	JAN 262	:U10 (Ben)	was Signat	gar	Kad.							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04275 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marjorie 2010 3:32p Levey January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3330 N. Leisure World Blvd. Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | Month, Days Year | 925 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** New York 1 🗆 M 2 🗶 F 103-16-2265 Director 84 Usual Residence of Decedent show 10b. County ian "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No <u>Maryl</u>and Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3330 N. Leisure World Blvd.. 20906 u.s.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 [X] No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Joseph Rabinowitz Sarah Meuers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12329 Chagall Drive, Gaithersburg, MD 20878 Miles Levey - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗓 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem 02/11/2010 Arlington, Virginia 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Lie 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1 1 months Immediate Cause (Final Physician Uterine Carcinoma with Metastatis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Diwito (unas e consequence d'): if any leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of) attending physician I for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the bur Box 68760 E FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 X No Month P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Aortic Stenosis 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of Diabetes Mellitus Type II 24a. Was an autopsy performed? death? Venous Thrombosis 1 ☐ Yes 2 🗶 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar 29b. Signature and title of certifie

Dawn Broderick. 31. Date filed (Month, Day, Year)

JAN 26 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D45956

18109 Prince Philip Drive, Suite #275, Olney, MD 20832

29d. Date signed (Month, Day, Year)

January 25, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jan. 27, 2010 George 1543 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Takoma Park Washington Adventist Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Min. Days Hours 2^M9707394, Y99749 Viet^{ry)}Nam Director 220-86-1731 60 Usual Residence of Decedent 10c. City, Town or Location Silver Spring 10a. State 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland by Funeral Director items 23a or 28a-f s ner must be notified MD Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 422 Eisner Street 20901 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian, event, the Medical Examiner Armed Forces?
1 ☐ Yes 2 🛣 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 Asian 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 'natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha Restaurant Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Nhon Nhut Lee Pauline Chau f Health and Menta item 27 is marked other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
422 Eisner Street Silver Spring, Md 2090! Su Hsia Li/Wife other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or otl Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State George Wash.Cem. 2/01/2010 4 Donation 5 Other (Spegify) Adelphi, Md Phittip ades rin wldi funeral service, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ 10 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine If any, leading to fininediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) signed by the a 2 🗌 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No I 🔲 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No ၉ 1 Tes 1 🗹 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 27. Mann f Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 2 Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined building, etc. (Specify) 24 hours 29a. Certifier 📝 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated з 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 1 29b. Signature and title 29c. License number 29d. Date signed (Month. Dav. Year)

Registrar
DHMH 17 Rev 7/2009

State

Name and address d

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completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:10p M Dorothu Luons Januaru Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fort Washington Prince George's Angel Lake Assisted Living 9. Birthplace (State or Foreign Country) Georgia Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8 Date of Birth Funeral 1 🗆 M 2 🗶 F Months 0 1975 74 928 Director 82 257-34-3130 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10h County within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Maruland Prince George's Fort Washington 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12113 Donnybrook Drive 20744 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify Completed 3 Widowed 4 Divorced White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sam Feinbera Ida Feinberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Lyons - Spouse #2214. North. Falls Church. 5601 Seminary Road. 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beth Shalom Cemetery 01/28/2010 | Columbia, SC 22. Name and Address of Facility Everly-Wheatley Funeral Home Si matu e of Funer Tervi Licensee L MD0707 1500 West Braddock Rd., Alexandria, VA 22302 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heard failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician Atherosclerotic Cardiovascular Heart Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month for Pregnant at time of death page 2 should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Dementia After this certificate has 2 🗆 No Yes 1 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examine 1 Yes 2 No Assisted Hospital ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined 24 hours a Funeral L Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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leted cause of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 9:20a M Gui. Tanuaru Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** Days Min. 1 □ M 2 🗓 F Months Hours 02/12/1923 China Director 86 213-08-4697 Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Silver Spring Maruland Montaomeru 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 1400 Fenwick Lane. 20910 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify. "natural", Specify. 3 X Widowed 4 Divorced Asian traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked ഉ Unknown Leung Li permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 20906 13203 Bluehill Road. Silver Spring. Kon Tam - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Heaven Cem. 01/30/2010 | Silver Spring. MD Signature of Funeral Şervice Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring. MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Septic Shock disease or condition resulting in death) Medical Examiner Colon Cancer Sequentially list conditions. Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No 5 Other (specify) Month Day Year be detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director, After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X N 2 🗌 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No ပ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c, Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No injury 1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month. Day, Year) D45471 January 21, 2010

State Registrar

DHMH 17 Rev 7/2009

1111 Spring Street, #214, Silver Spring, Maryland 20910

on who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

M.D.

Yeheyis Negussie

31. Date filed (Month, Day, Year)

Physicia Medic Examin Funeral Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ Medical Examiner Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and physician properties of filled in by the funeral director, page 2 should be detached for use as the burial-transit.

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	13418 Briar Path Lane 5. Social Security Number 6. Sex 7. Age (In y	rs. last birthday)	If Under 1 Year	lver Spra If Under 24 Hrs.	8. Date of Birth		ontgo	mery e (State or Foreign
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ector	10a. State 10b. County 10c Maryland Montgomery	c. City, Town or Lo		r Spring				Inside City Limits 1 ☐ Yes 2 🕅 No
al Di	10e. Street and Number		10f. Zip Code		10	g. Citizen of Wh	•	
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Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	l'	Vas Decedent of His f Yes, specify Cubar	, Mexican, Puerto	Rican, etc.)		· American I White, etc.	sian
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	1 Burial 2 🛛 Cremation 3 🗆 Removal from State		natory or other place)		0c. Location - C		
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	21. Signature of the real set the Light see							MD 20904
	23a. Part 1. Exter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lung Ca. Due to (or as a condition or condition or condition or condition or condition or cause or condition o			, such as cardiac c	or respiratory arres	,	Int	pproximate erval Between nset and Death UCOUS
edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last b. Due to (or as a condition of the condition of the cause of the cau							
Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 │ Yes 2 ☑ No 9 │ Unknown 23c. If yes, outcome of pri 1 │ Live Birth 2 │ 4 │ Pregnant at time 9 │ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date Mont	,	y Year
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complet					24a. Was an autopsy perform	ed? pri	ere autopsy or to compleath?	findings available etion of cause of
Be (25. Was case referred to medical examiner?			ce of Death (Check				
욘	1 ☐ Yes 2 🕱 No Hospital: 1 ☐ Inpatient : 27. Manner of Death 28a. Date of injury	2 ER/Outpatier		4 ☐ Nursing Ho	me 5 🕅 Residen			·
ate	1 X Natural 5 ☐ Pending (Month, Day, Yea		work		28d. Describe how	injury occurred		
Certifi	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - A building, etc. (Sp				28f. Location (Stree City or Town,		or Rural Ro	ute Number,
Medical Certificate:	29a. Certifier (Check only one) 1	nation and/or invest	tigation, in my opinio death occurred at the	n, death occurred at time, date and plac	the time, date and	place, and due to	o the cause	
	29b. Signature and title of certifier B, Shere	mD		number D21910	29	d. Date signed (i		
	30. Name and address of person who completed cause of death Poten B. Shenen M.D. 392	(item 23a) (Туре, F 1 	erint) a. Drivo	Wheaton	Marulano	1 20906		
е	Peter B. Sherer, M.D., 392 31. Date filed (Month, Day, Year) JAN 28 2010 33. Registrar's S	ignature	, Kel		05.000110			
r 09	JAN 20 LUIU Comas	F. 1900						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 () 04280 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** A^{M} Anna M Lipscomb 1 26 2010 6:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 41 West I Street Brunswick Frederick If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) 5/26/1924 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 1 □ F 219-12-2446 85 Director VA. Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show the Medical Examiner must be notified at Director 1X Yes 2 No Frederick Brunswick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 41 West I Street Funeral 21716 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💥 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 9 21215-0036 1 □Yes 2X No Specify \$ 3 Nidowed 4 Divorced "natural", Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health, and Mental Hygienn Important: If item 27 is marked other that any injury or other traumatic event, event, e 8 Housewife Home Maker Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ္ပ Noah Haskins Nora Parker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nora Hosby, Daughter 41 West I Street, Brunswick MD 21716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pleasant View Gardens 1/29/2010 Martinsburg W 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barlism John T Williams Funeral Home, Brunswick MD. 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** adenocascinona nonths /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to for as a consection of off cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed burjal-trar Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) P.O. detached 9 ☐ Unknown 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 3 Probably 4 ☐ Unknown 1 ∏Yes 2 ∏No Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 □Yes 2 12 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? Hospital or Attending Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 24 hours after death Funeral Director: filled in by the Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 [Livertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the within To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brunswick, 3 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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			Registrar 1. Decedent's Name (First, Middle, I	_ast)	-			ie oi	Dean	,	2. Date of De				3. Time	of Death
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	ems 2	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 1	3. Was Dec			Drigin? (S an. Puert	pecify Yes or No o Rican, etc.)		14. Race		an Indian,	
36	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show deal Exeminat rust be notified at	by F.	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ∐Yes 2 ⊠ 1 If Yes, Give	Vo		1 □Yes						Specify:	Whit		
215-0036	hour houral	edt	15. Decedent's	Year or Dates:		16a. De	cedent's Us	ual Occu	pation			16b. K	ind of Busi			
215	within 72 iene. than "n a	Completed	(Specify only highest of Elementary/Secondary (0-12)	grade completed) College (1-4or 5	i+)	(G life	ive kind of v	ork done use retire	during mo ed)	ost of wor	king	-				
21	filed withir Hygiene. other than		12			Envi	ronme	ntal					anito		<u> </u>	
and	d be fill ed ot ed ot	Be c	17. Father's Name (First, Middle, La Raymond Koslosk								ne (First, Middle	, waiden	Surname)			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Heatht and Mental Hyglene. The marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exercites russ be notified at	ည	19a. Informant's Name/Relationship			19b. Ma	ailing Addre	ss (Street			Papanek Iral Route Numb	er, City o	or Town, S	tate, Zip	Code)	
	1 and 2 Health a em 27 is		Diane Benecky -	daughter		6322	2 East	ern	Star	Way	Clarksv	ille	, MD	210)29	
altimore,			20a. Method of Disposition 1 ☐ Burial 2 ※ Cremation 3	☐ Removal from State	20b. P	lace of Dis emetery, c	sposition (N erematory or	ame of other pla	ce)		Date	20c. L	ocation - C	ity or To	wn, State	
ţ			4 ☐ Donation 5 ☐ Other (Spe	cify)			Crema				1/2010		lanove			
Ba	permit. Departr Imports any Inju		21. Signature of Funeral Service Lic	in-wt	1044		22. Name				rry H. Pike El					
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on	mplications that cause	the deat	h. Do not								Lyg	Approxim	nate
- dia	Physician		Immediate Cause (Final disease or condition	N	2ATI	ON	PNI	EU W	ION	ITIS	e			د	Onset ar	
	/Medical Examiner		resulting in death)	Due to (or as												
		e.	Sequentially list conditions, if any, leaving to immediate	b. SE	PSIS	uanoa offi										-
	cuted id ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events				RY	FA	Lu	RE						
,00	e exertian ar urial-tr		resulting in death) Last	Due to (or as			1									
68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	edical		d										_		
Вох 6	leath certific attending p for use as f	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome									23d. Date	of delive	rv	
	death e atte	icial	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 ☐ Feta It time of c		3 ☐ Ectopio 5 ☐ Other (су				Mont		Day	Year
P.0	ires that the de signed by the a be detached	Physician/M	9 ☐ Unknown								00- Did.	t-b	use contrib	4- 40-		of dooth?
ds,	iires th signe d be d	l by	Part II. Other significant conditions PARKINSO I	•			e undenying	cause gr	venin Fan	t 1.						Unknown
of Vital Records,	w requir been s should	Completed	DEMENT		-1)3						24a. Was					gs available
Re	The lar	dwo	COPD	()							auto perfe		pri de	or to con ath?	npletion o	of cause of
ita	ysician: Th iis certificate director, pag	Be C	25. Was case referred to medical examiner?						26. Pla	ce of Dea	1 □Yes ath (Check only		, ,,	_Yes	2 120110	
of V	Physic rthis ce ral dire	၉	1 Yes 2 No			-	tient 3 🗌	JOA		Nursing H	lome 5 ☐ Res				′)	
ouo	ding F h. After funera	tion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Inju (Month, Da	ıry ıy, Year)	28b. Tim- Injui		28c. Inju Wo 1 F	ıryat rk? ∃Yes 2[∃No	28d. Describe	how inju	ry occurred	ı		
Division	Atten r deat sctor: by the	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Inj	ury - At ho	me, farm,					28f. Location	Street a	nd Number	or Rura	Route N	lumber,
	tal or rs afte al Din led in	Cert	4 Informiciae	building, et	c. (Specii	y) 					City or To	wп, Stat	e <i>)</i>			_ 1
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Medical		Physician: To the best aminer: On the basis of	of examina											e(s)
	o the	Mec	29b. Signature and title of certifier	and manner st	ateu.		2	9c. Licen	se numbe	r		29d. Da	ate signed	Month, L	Day, Year	·)
			1 Suct	21/1	M	0		DE	95	17		FE	ER	02	2	010
	4		30. Name and address of person wh	o completed cause of c		n 23a) (Typ			^		1					
	\ 		31. Date filed (Month, Day, Year)	S HASA 32. Fregistr		M · D	. 5	177	(E)	DAR	LN	LOL	umb	IA,	MD	21044
	Sta Registr	-	FEB 0 3	noto A	was signe	A. x	banks	1								

DHMH 17 Rev 1/2001

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	_ FOI	epartment of Health and M Certificate of Death	lental Hygiene Reg. No. 2010 04282
Physician	1. Decedent's Name (First, Middle, Last)		Date of Death Month Day Year 3. Time of Death
/Medica	4- South North Mark in the first in the standard comband	4b. City, Town, or Location of Death	February 15, 2010 1:10 PM
Examine	Greater Baltimore Medical Center [5. Social Security Number	Towson	Baltimore 8 Date of Birth 9. Birthplace (State or Foreign
Funeral Director	0.1 m	rs. Months Days Hours Min.	(Month, Day, Year) Aug. 11, 1927 Maryland
and	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location	10d. Inside City Limits
a-f sho	Maryland Harford County Fallsto	on	1 □ Yes 2 ⊠ No
vith the Mar	10e. Street and Number 3230 Canterbury Lane	10f. Zip Code 21047	10g. Citizen of What Country? United States
fler death w	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	
Il', o	If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2X No Specify:	Rican, etc.) Black, White, etc. Specify: White
ed within 72 hou ygiene.	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	16b. Kind of Business/Industry
led wit Hygien Hygien her thi		Beautician 18 Mother's Name	Hair Salon e (First, Middle, Maiden Surname)
Vidilion wild be fill Mental H arked out	T	Ruth Dav	
ary and M and M is mar		Mailing Address (Street and Number or Rur	al Route Number, City or Town, State, Zip Code)
C, IV		3702 Springstone Cou	rt Clifton, VA. 20124 Date 20c. Location - City or Town, State
mit. Pages 'mit. Pages 'partment of borlant; if ite y Injury or of ce.	4 Donation 5 Other (Specify) Morelan	nd Mem.Park Feb	.20, 10 Baltimore, Maryland
Dermit Depar Impor any In once.	21. Signature of Funeral Service Licensee Robert W. Groves, Jr	Z3Z3 YOLK ROBO TI	Funeral & Cremation Center, P.A. monium, Maryland 21093
	23a. Part 1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.	C . :	or respiratory arrest, Approximate Interval Between Onset and Death
Physician /Medical	disease or condition resulting in death) a. Due to (or as a consequence or		
Examiner	Sequentially list conditions, b. Sport of or as a consequence of	neons bleed o	neoumadin
uted	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events	ancer/pancies	the cancer
portory, icate be executed physician and the burial-transit	resulting in death) Last Due to or as a consequence o		
por ou,	d		
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as:	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
e law requires that the de has been signed by the je 2 should be detached	Part in Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ▼No 3 ☐ Probably 4 ☐ Unknown
The law required that the same			24a. Was an autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No
ician: 1	25. Was case referred to medical examiner?	26. Place of Deat	h (Check only one)
ding Physician: The ding Physician: The The funeral director, page	To les 2010 Tampatient 2 ER/Out	ime of 28c. Injury at	ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred
tending leath. tor: Afte the fune	1 Matural 5 □ Pending (Month, Day, Year) In 2 □ Accident investigation	ijury Work? M 1 ☐ Yes 2 ☐ No	
tal or Attending P is after death. al Director: After led in by the funers	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the			
Vithir comp	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
20 Pl	20 Name and address of party who completed arrive of death (U. a. 2021)	1)38/1/2	2-16-3010
	30. Name and address of person who completed cause of death (Item 23a) (VONCIS S 40TOLO 2005 31. Date filled (Month, Day, Year) 32. Persistrar's Signature	KRd Ste 22, Lu	theville MD 21093
State Registra	FFP 4 - COLD A	had	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1.40 A M Physician/ Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Harwood Mandrin House If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number **Funeral** Days (Month, Day, 12/13) 1 M 2 F Yrs 86 **Director** 220-14-8446 Usual Residence of Decedent 10d. Inside City Limits 23a or 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10b County 10c. City. Town or Location Director Anne Arundel Annapolis 1 Yes 2 No Maryland 10e, Street and Number 10f. Zip Code 10a. Citizen of What Country? USA 21403 Funeral 21 Silverwood Circle Apt 11 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? ۵ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate <u>Real Estate Broker</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Elsie Kruse Harry Fretwell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 520 Hillsmere Drive, Annapolis, MD 21403 Diane Myers - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once, 1/27/2010 Baltimore, MD Baltimore Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St, Annapolis, MD 21401 Tilleter 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final morth Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day for Pregnant at time of death
Unknown the detached 9 Unknown s been signed by t should be detach "Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy has page certificate 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be Hospital Other: 4 Nursing Home 5 Residence 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 은 this (28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signatuje and title of certifie 39. Name and address of person who completed cause of death (Item 23a) (Type, Pri gistrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar 04284 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MORRIS OWARD LAU 0410 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel <u> Anne Arundel Medical Cepter</u> 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Numbe **Funeral** (Month, Day, 1 M 2 D F Months Hours 215-38-9186 88 Yrs Ohio Director . 1921 January Usual Residence of Decedent shov or 28a-f shov notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Anne Arundel Annapolis Maryland 10e. Street and Numbe 10f. Zip Code ò 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a on any injury or other traumafic event, the Medical Examiner must be, and injury or other traumafic event, the Medical Examiner must be. Funeral 2517 Bollard Road 21401 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 Never Married 2 x Married δ X Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White If Yes, Give Year or Dates. 1939-62 3 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Payroll Administrator Finance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Howard Morris Ruth Van Horn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beatrice Morris/ Wife 2517 Bollard Rd., Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 1-28-2010 Edgewater, Maryland Other (Specify) 4 Donation 22. Name and Address of Facility George F. Kalas Funeral Home 21. Signatur Fun 2973 Solomons Island Rd., Edgewater, MD 21037 r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Ent shock, o heart failu Immediate Cause (Final heart failure. List only one cause on each line Priysician onch disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or) Exam attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months? Month 4 Pregnant : 9 Unknown Pregnant at time of death 1 Yes 2 No the signed by till Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown cate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician; The law autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 1 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2/ No 1 Yes ပ ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a, Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Date signed (Month, Day, Year)
Thurany 28, W/0 29b. Signature and title of certified 29c. License number 6 on who completed cause of death (Item 23a) (Type, Print) State

Registrar

ank

ι		Please	Type or Print in				-		ole.
		For State	State of Maryl		artment of F r <i>tificate of</i> .		-	giene Reg. No. 2	10 01.205
Division		Registrar 1. Decedent's Name (First, Middle, L			inoute or		2. Date of De	eath	3. Time of Death
Physicia /Medic	al	Judith Ann Werl					Januar		
Examin		4a. Facility Name (If not institution, ganne Arundel Me	dical Center		An	r Location of Death			ne Arundel
Funeral Director		216-34-5217		yrs. last birthday) '4 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da June 1	2, 1935	9. Birthplace (State or Foreign Country) Pennsylvania
ryland how	·	Usual Residence of Decedent 10a. State 10b. County Maryland Anne A		. City, Town or Lo		polis			10d. Inside City Limits
ith the Marylan or 28a-f show	Funeral Director	10e. Street and Number 1756 Dunton Road			10f. Zip Code			10g. Citizen of W	
eath wi	eral		12. Was Decedent Ever i	- 11 C 10 1		401	anifu Van or Na		S.A.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evertical must be redified at once.	ğ	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?		was becedent of P If Yes, specify Cuba 1 □Yes 2 🛛 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Specify:	, White, etc.
72 ho	eted	15. Decedent's (Specify only highest g	Education rade completed)	(Give	dent's Usual Occup	during most of work	ring	16b. Kind of Bus	siness/Industry
within giene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 4	life. I	Soprano	a)		Mu	sic
uld be filed Mental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Las Harry Werle	ot)	<u> </u>		18. Mother's Nam Dorothy		, Maiden Surname	2)
und 2 shoralth and 1 27 is ma er trauma		19a. Informant's Name/Relationship Philip Meeder/h	(Type. Print) usband	19b. Mailir 1756	ng Address (Street Dunton	and Number or Ru Road Ann	ral Route Numb apolis,	er, City or Town, S Marylan	State, Zip Code) d 21401
ages 1 a ent of He nt: If item y or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State		sition (Name of natory or other place Cremato	ce)	Date /2010		City or Town, State
permit. F Departm. Importar any Injur		21. Signature of Funeral Service Lic	"	22	2. Name and Addre	ss of Facility JC	hn M. T	aylor Fu	neral Home
20 5 # 9		23a. Part 1. Enter the disease, or co	enlications that caused the c						olis, MD 21401
Physician		shock, or heart failure. List on Immediate Cause (Final disease or condition	y one cause on each line.	The second	or the mode or dyn	ig, sacif as cardiac	or respiratory a	most,	Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):					
uted Insit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b Due to (or as a con	sequence of):					
eath certificate be executed attending physician and for use as the burial-transit		that initiated events resulting in death) Last	c. Due to (or as a con	sequence of):					
rtificate ng phys as the	Medic	IF FEMALE:	d						
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the i	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ If 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	у		23d. Date Mon	e of delivery hth Day Year
e law requires that the de has been signed by the e. 2 should be detached	þ	Part II. Other significant conditions	contributing to death but not	resulting in the ur	nderlying cause giv	en in Part I.			bute to the cause of death?
v requir been s should	eted	Metastertic 13	Mail Cell C	ancer	•				3 Probably 4 Unknown
: The ław icate has ; page 2 s	Completed						24a. Was auto perfo 1 □ Yes	psy pr prmed? de	/ere autopsy findings available rior to completion of cause of eath? ☐ Yes 2 ☐ No
ysiciar s certif directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2 ☐ ER/Outpatien	ot 3 DOA Oth	er: 4 Nursing H		one) idence 6 □Othe	ar (Specify)
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day, Yea	28b. Time of	28c. Injur Wor			how injury occurre	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ertifica	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		At home, farm, streecify)	eet, factory, office		28f. Location (City or To		er or Rural Route Number,
e Hospita 24 hours e Funera letely fille	Medical C	29a. Certifier (Check only one) Certifying I	Physician: To the best of my aminer: On the basis of exar and manner stated.	knowledge, death	n occurred at the tivestigation, in my o	me, date and place opinion, death occur	, and due to the red at the time,	cause(s) and ma date and place, a	nner as stated. nd due to the cause(s)
To the within To the comp	Me	29b. Signature and title of certifler	b und)	29c. Licens	e number		29d. Date signed	(Month, Day, Year)
110-		30. Name and address of person wh	completed cause of death ((Item 23a) (Type,	Print)	2001 Medi			apolis, MD
Stat		31. Date filed (Month, Day, Year)	2010 32. Registrar's Si	ignature	TIVIC		21	401	
Registra	ar	UNIVO	Server	P. A	varke				

1. Decedent's Name (First, Middle, Last)

Reg. No.

2 Date of Death

Physician
/Medical
Examiner

M 51:40 KING WILSON MUNGAI 700 2010 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death PRINCE GEORGES PRINCE GEORGES HOSPITAL CENTER CHEVERLY 8. Date of Birth (Month, Day, MAY 27, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1₩ 2□ F KENYA, AFRICA 25 1984 Director 471-45-1697 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ir than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at **X**□Yes 2□No Director MARYLAND CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 111 MALLARD LANE 20646 KENYA, AFRICA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 □Yes 2 X No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) INFORMATION TECHNOLOGY TECH. TECHNOLOGY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SAMUEL MUNGAI KINOTHI ROSEBELLA BINNS MUNGAI of Health and Mente I Item 27 Is marked r other traumatic er ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOYCE C. WILSON-MUNGAI / WIFE 111 MALLARD LANE, LA PLATA, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State Department of I Important: If Its any Injury or o 1 Deurial 2 □ Cremation 3 □ Removal from State MUNGAI FAMILY CEMETERY 2/8/2010 MAII-MAHIU, KENYA 4 ☐ Donation 5 ☐ Other (Specify) LYDIA C. THORNTON JOHNSON MO0583 22. Name and Address of Facility
THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final antro abdominal Jacorations **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner motor Aquichle Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) be executed burial-transi Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IE FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.O. s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 TYes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner2 1☐1es 2☐No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred. 51 144 Con Trailer of 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 ☐ No spital or Attendi nours after death. neral Director: A investigation 28f. Location (Seet and Number or Rural Route Number, City or Town, State) No 77% bound 2. Accident 6 Could not be 3 ☐ Suicide determined 4 Homicide STREET Rocks 301, upper Northbord

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hospital within 24 hours a To the Funeral E 29a. Certifier | Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 000 43183 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAREN R. BROOKS, M.D. 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

State

Registrar

31. Date filed (Month, Day, Year)

JANZS

32. Registrar's Signature

10-00536	
Detrich L. McDonald	
	1
Physician/	
Medical Examiner	

Funeral

Director

e notified at once.

If item 27 is marked other than "natural", or items her traumatic event, the Medical Examiner must be

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Completed

Examiner

Physician/Medical

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Completed

Be

Certification:

Medical

2

1 Natural

Accident

more, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.

Baltimore.

Physician

/Medical

Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1418 hrs January 19, 2010 DIETRICH MCDONALD 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince George's 200 Harry S Truman Drive Largo 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Months Days Min Hours Country) ILLINOIS 1 M 2 F 1976 328-64-7509 Usual Residence of Deceden 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 XYes 2 No ONSLOW NC 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 226 SMALLWOOD RD 28539 U.S.A 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 2 X Married 1 Never Married 2 No 1 X Yes 4 Divorced If Yes, Give Yea 994-2010 1 Yes 2 No specify: Specify: BLACK 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 3 U.S. MARINE DEFENSE 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) NERVELL CONEY MARY MCDONALD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHERELL M. MCDONALD/WIFE 205 HARRY S. TRUMAN DR., LARGO, MD. 20774 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State crematory or other place) WELLS GROVE CEMETERY JAN.30,2010 CLINTON, MS Donation 5 Other Specify 22 Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 21. Signature of Funeral Service Licensee Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and failure. List only one cause on each line a. Contact Gunshot Wound of Head Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of). events resulting in death) Last UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Year Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Hospital. 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day,Year) FOUND: 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death

The law requires that the death certificate be executed ending physician and use as the burial - tran 68760 the attending Box Ö Δ. Records, After this certificate has Division of Vital

signed by the betached s been s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After the Total Physician or To the Funeral Director. the filled in by completely

28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 200 Harry S Truman Drive, Largo, MD determined (Specify) Park/Recreation Area 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

FOUND

1416 hrs

30. Name and address of person who completed cause of death (Item 23a)

Pending

Investigation

Jan 19, 2010

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

O.C.M.E

1 Yes 2 V No

31. Date filed (Month) State Registrar

Russell Alexander MD

January 20, 2010

Subject shot self

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Richard Clemens Mocarski 12:25 A^M February 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 3 M 2 □ F 059-30-3496 **Director** Sept. 18,1938 New York Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show r than "natural", or items 23a or 28a-f sho 1 ☐Yes 2 TNo Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8700 Hawkins Creamery Road 20882 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or ite any filury or other traumatic event, the Madical Examina 1 ☑Yes 2 □ No 1956—
If Yes, Give
Year or Dates: 1958 1 ☐ Never Married 2X Married 1 ∐Yes 2 ☑ No þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Small Business Owner Travel Agency Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Casimir Francis Mocarski Lauretta Bertha Akalski ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8700 Hawkins Creamery Road, Gaithersburg, MD 20882 Jean H. Mocarski (Wife) Baltimore, 20b. Place of Disposition (Name of cemetery crematory or other place)
AIL Souls
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition February 4, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Germantown, MD 22. Name and Address of Facility 21. Signature of Foneral Serv DeVol Funeral Home, M00689 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. The the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shirts, differ failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Section folly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): executed burial-tra Due to (or as a consequence of): Box 68760, or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) P.O. 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 □Yes 2 🗹 No 1 □ Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA this Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mannet of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Matural s after dea. al Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year)

15+1

State Registrar GREGORY ITT 31. Date filed (Month, Day, Year)

FEB 03

DHMH 17 Rev 1/2001

15225

32. Registrar's Signature

ShAdy Grove Road Rockville, MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3her

Registrar

OCME

RECORD

			For State Registrar	State of	Marylar		artment of F r <i>tificate of I</i>	lealth and N <i>Death</i>		jiene _{eg. No.} 2 ∩	10	01,290
			Decedent's Name (First, Midd	lle, Last)					2. Date of Deat	th	1.0	3. Time of Death
	Physici /Medic		ELI	ZABETH I	. Mc	CORMIC	K		JAN.	27, 2	Year 2010	3:00 P M
	Examin		4a. Facility Name (If not institution	on, give street and num	ber)		4b. City, Town, or	r Location of Death		4c. County	of Death	
1			SACRED HEART					TTSVILLE	La Barrataria			GEORGES
	Funeral		5. Social Security Number	6. Sex 7		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Cou	place (State or Foreign ntry)
	Director		579-18-5982 Usual Residence of Decedent		94				AUG. 8,	1915	<u>WAS</u>	H. D.C.
	ylanc how	.	10a. State 10b. County	,	10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
	e Mar	Director	MD. PRINC	E GEORGES			HYATTSVII	LE				1 XiYes 2 ☐ No
	iff th	Dire	10e. Street and Number				10f. Zip Code		1	0g. Citizen of \	What Cou	ntry?
	s 23a	era	4410 OGLETH			0 10	2078				S.A.	
	ter de	Funeral	11. Marital Status1 ☐ Never Married 2 ☐ Ma	12. Was Deced Armed Ford 1 ☐ Yes 2	es?	.5.	If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		ck, White,	can Indian, etc.
21215-0036	thin 72 hours after death with the Maryland e. an "natural", or items 23a or 28a-f show "Midgel Evaluine", unt be netfined at	ģ	3 XWidowed 4 ☐ Divorce	If Yes, Give)		1 □ Yes 2 📉 No	Specify:		Specify	v: W	HITE
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			17. Father's Name (First, Middle	(4)		U.	S. DEPUTY	MARSHALI 18. Mother's Nam			GOV	'T.
anc	be d d	Be			CEN				•		,	
Maryland	2 should be n and Mental is marked or raumatic ev	욘	EMIL 19a. Informant's Name/Relation	PETER ship (Type, Print)	SEN	19b. Mailii	na Address (Street	and Number or Rui	IRENE ral Route Number		MARA State, Zii	o Code)
	s 1 and 2 should if Health and Mer Item 27 is marke other traumatic		CECELIA E. RO		ER	6108	SHERBORN	LA., SPI	RINGFIEL	D. VA.	2215	2
Je,			20a. Method of Disposition		20b. l		sition (Name of natory or other place	ce)		20c. Location -		
Ē	Pages nent of ant: If Its ury or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (ate			ERY 2-3-2	2010	BRENTWO	OD.	MD.
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service	Lioerisee	(i)	Ĉ	Name and Addre	ss of Facility UNERAL HO	OME & CR	EMATORI	UM, P	.A.
			23a. Part1. Enter the disease, of	or complication, that cal		0091 5	ROT CLEAR	LAND AVE	, KIVER	DALE, M	iD. 2	0/3/
	D!!-!		shock, or heart failure. Lis Immediate Cause (Final	t only one cause on ea	ch line.			.9, -2 2	or respiratory arr			Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	ORGAN ras a consec	FAILUR:	E				-	
	Examiner					G DISE	ASE					
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	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· · ·	CANCE							
60,	be ex ician ourial	E	resulting in death) Last	Due to (o	r as a consec	quence ot):						
68760,	ficate be executed physician and s the burial-transit	edical		d								
_		/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco						23d. Da	te of deliv	rerv
Box	law requires that the death cert as been signed by the attendin 2 should be detached for use a	Physician/M	in the past 12 months?	4 🔲 Pregna	rth 2 ☐ Feta ant at time of		Ectopic pregnanc Other (specify)	у			onth	Day Year
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ord	equire		HYPERTENSI	ON					1 □ Y∈	es 2 □ No	3□ Pro	bably 4 XUnknown
ec	e law r has b	Completed	OSTEOARTHR	ITIS					24a. Was a autops	SV .	prior to co	opsy findings available ompletion of cause of
of Vital Records,	Th sate pag	ပ္ပ							perfori 1 □ Yes		death? 1 ☐ Yes	2 □No
Z.	Physiclan: r this certific ral director, I	a	25. Was case referred to medical examiner?	Hoenital:			Oth	26. Place of Deat				
of	Physer this eral di	: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of	Injury	ER/Outpaties 28b. Time o	IL 3 LL DUA	4X_J Nursing He	ome 5 Reside		. ,	ffy)
lon	nding th. : Afte e fune	tio	1 Natural 5 ☐ Pendi		, Day, Year)	Injury	f 28c. Injur Worl M 1 □	Ŕ? Yes 2 □No │		,,		
Division	Atter	ifica	3 ☐ Suicide 6 ☐ Could	nined 286. Place of			eet, factory, office		28f. Location (Si	treet and Numb	er or Run	al Route Number,
Ö	tal or s afte al Dir ed in	Certification:	4 Hornicide	ballani	g, etc. <i>(Speci</i>				City or Towi	n, Slate)		
	To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical		ng Physician: To the b I Examiner: On the ba and manne	sis of examina							
		Me	29b. Signature and title of certifi	7)			29c. Licens	e number		9d. Date signe		
	3			the the			1019	1609	/ /	- 29.2	1010)
	-		30. Name and address of person		·		·	*		0.0.7.5.		
	Sta	te	31. Date filed (Month. Day. Year	LI, M.D.	gistrar's Signa	36UL TA	AYLOR ST.	, BRENTWO	OUD, MD.	20/22		
	Registr	_	FEB 01	2010 /2	Man A	ature L. Jan	Kis					
				Julian	- 10					-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 28, 2010 12:56 рм Elizabeth McCauley Marion Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 10201 Carson Place Silver Spring Montgomery 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) D.C. Days 1 □ M 2 1 F Hours April Day (Year) 1922 577-20-7131 87 Director Usual Residence of Decedent filed within 72 hours are:

tal Hygiene.

ed other than "natural", or items 23a or 28a-f show
e ovent, the Medical Examiner must be notified at. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? Funeral 10201 Carson Place 20901 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black White etc. þ 1 Never Married 2 Married 2 No Yes 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Checker Supermarket Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked out any injury or other traumatic even once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Pruitt Ann Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Alexander L. McCauley/Husband 10201 Carson Place, Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 31 Jan. Metropolitan Crematory 2010 4 Donation 5 Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licensee Francis Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause on each line. Immediate Cause (Final Onset and Death more than Physician/ Chronic Obstructive Lung Disease disease or condition resulting in death)) Medical Due to (or as a consequence of) 10 years Examiner Sequentially list conditions. it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) and that initiated events resulting in death) Last Due to (or as a consequence of) physician al s the burial-t Physician/Medical certificate be attending p as nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death Day Year the detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hyperparathyroidism, History of Lung and Breast Malignan! 1x Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed?
☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🔀 Residence 6 Cother (Specify) 1 Tyes 2 XNo ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 XNatural 5 Pending 1 🗌 Yes 2 🗌 No ieral Director: A filled in by the fu Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D44290 February 1, 2010 MD

Registrar

State

Box 68760

P.O.

Records,

Division of Vital

6900 Georgia Ave., Ward 73, Washington, DC 20307

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

Timothy L. Krohe, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201 a 5:45 рм January Murdock Medical Rose 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 13825 Vintage Lane Montgomeru Silver Spring Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Country) New York 1 □ M 2 🗓 F Months Days Hours 08/05/194 **Director** 154-32-9622 66 Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maruland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13825 Vintage Lane 20906 U.S.A. 1 and 2 should be filed within 72 hours after death wif Health and Mental Hygiene.
item 27 is marked other than "natural", or items: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? ₽ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) **5**+ Elementary/Seconday (0-12) Psuchological Therapist ACCI 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Axelrod Rikka Margolit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13825 Vintage Lane, Silver Spring, Maryland 20906 Myron Murdock - Husband 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u>Lebanon Cemetery | 01/29/2010 |</u> Adelphi. Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring. MD 20904 23a. Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Metastatic Pancreas Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 X No Yea 4 ☐ Pregnant at time of death g ☐ Unknown been signed by the should be detached 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 No Yes 2 X No 1 Tyes To the Hospital or Attending Physician: " within 24 hours after death. To the Funeral Director: After this certifics within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? 2 X No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural injury work? 5 Pending 2 No ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month. Dav. Year) 20 MD19655 January 28, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marshall. MD 3800 Reservoir Road, NW, Washington, DC 20007

DHMH 17 Rev 7/2009

State

Registrar

Year)

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day 25 Month **Physician** 7:40 AM Januar argaret /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 67 1942 May 1, Pennsylvania 195-32-1553 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Director ms 23a or 28a-f s must be notified Mechanicsburg Cumberland PA 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number United States 4902 Carlisle Pike #265 17050 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or iten edical Examiner r 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Caucasian þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry l other than "natur vent, the Medical F 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be h and Mental F 27 is marked or traumatic eve Anna Carey Glenn Heberling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4902 Carlisle Pike #265
Mechanicsburg, PA 17050 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 i any injury or other tra Harvey A. Miller, Husband 20c. Location - City or Town, State 20a. Method of Disposition
1 □ Burial 2X Cremation 3X Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. Schaefferstown, PA Con O Lite Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2010 Signature of Funeral Service Licensee 22. Name and Address of Facility Parthemore Funeral Home & Cremation Services, 1303 Bridge Street, New Cumberland, PA 17070 M01508 1303 Bridge Street, New Cumberland, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Depsis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events Examiner Due to (or as a consequence of) physician and is the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 2 No 2 ER/Outpatient 3 DOA 6 Other (Specify) 1 Tes မှ this Director: After this d in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide City or Town, State) within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number may 25, 2010 RES-000

Registrar DHMH 17 Rev 1/2001

10

600 North Wolfe St, Baltimore, MD, 21287

mD

32 Registrar's Signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Scialla

limothy

0-01009 Sharon Maslan		Please Type or Print in Black Indelible Ink.	Ensure All Copie	s Are Legi	ble.2010	1 14291
onaton wasian		State of Maryland / Department of He 1- For State Certificate of De		_	0 1 0	0123
Physici Medical Exam	an/ iner	1. Decedent's Name (First, Middle, Last)		Reg. 2. Date of Death Month D February 3, 2	ay Year	3 Time of Death 1815 hrs
1			y, Town, or Location of Death esville		4c. County of Death Baltimore Cou	
Funeral Director			Inder 1 Year If Under 24Hrs. Inths Days Hours Min.	8. Date of Birth(1 06/16/1	MM/DD/YYYY) 9. Bir Foreig Co	
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show any tranmatic event, the Medical Examiner must be notified at once,	To Be Completed by Funeral Director	7 Granary Drive 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes Specification (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Special 17. Father's Name (First, Middle, Last) Stanley Goldrich	Zip Code 21208 edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto I 2 \(\sum_{\text{No}} \) No specify: ual Occupation (Give kind of www.orking life. DO NOT use retined to the company of th	ecify Yes or No-Rican, etc.) ork done ed) a cher (First, Middle, Maio	White, etc. Specify: Whi Sb. Kind of Business/I Public Sc den Surname)	es can Indian, Black, te ndustry hools
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and h Important: If item 27 is n injury or other traumatic	_	Gary Maslan, Former Spouse 7508 Eas 20a. Method of Disposition (Note The Paragraph of Place Of Disposition (Note The Paragraph of Place of Disposition (No	tern Ave., Ba Name of cemetery, ce) al Gardens 02 and Address of Facility nSKY Hebrew F	ltimore, Date 20 /08/10 uneral Ho	MD 21224 Oc. Location - City or Olney, Mome	Town, State
Physician Examiner pur un un i, unan	cal Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the modification failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to the resulting cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last AMENDED. AMENDED.	m, alprazolam tion	and alco		Approximate Interval Between Onset and Death
D. Box 68760, the death certificate be. by the attending physicial thed for use as the buria	Physician/Medi	AMENDED AMENDED 23a,PII,27,28a-f,pi 23c. If yes, outcome of pregnancy 1	th 3 Ectopic pregnan	23e. Did tobac	co use contribute to t	ay Year he cause of death?
tal Records, P.C.	Completed by	Atherosclerotic cardiovascular diseas	e and	1 Yes 2 24a. Was an autopsy performed 1 Yes 2	prior to co	opsy findings available ompletion of cause of
ion of Vital I tending Physician: teath. tor: After this certifi the funeral director,	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No 1 Natural 5 Pending 2 Accident Investigation Natural 2 ER/Outpatient 3 ER/Outpatient	28c. Injury at Work?		idence 6 🗹 Other:	Scene
Divis To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Il Certification:	3 Suicide 6 X Could not be determined (Specify) found in yard of 29a. Certifier	residence I	or Town, State Pikesvill	7 Granary e, MD	
To the Hower within 24 has To the Function Completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated 29b Signature and fittle of certifier 20b Signature and fittle of certifier 20b Signature and fittle of certifier 20b Signature and fittle of certifier 20b Signature and fittle of certifier 20b Signature and fittle of certifier 20b Signature and fittle of certifier 20b Signature and fittle of certifier		the time, date and		cause(s)
		 Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn 5 	Street, Baltimore, MD 2	21201		
St Regist		31 Date filed (Month, Day Year) 2010 32 Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 04295 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary May 7 05 PM Medical January 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Hospital Frederick Memorial Frederick 5. Social Security Number Funeral 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F 217-28-0993 Hours My 1 5 1 1918 COMPTS) 92 Director Usual Residence of Decedent ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director MD Frederick Mt Airy 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 511 Lewis Ct. 21771 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 2 XNo 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) operator telephone co Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name *(First, Middle, Last)* Harry B. Eccard 18. Mother's Name (First, Middle, Maiden Surname) Orpha Stottlemyer 19a. Informant's Name/Relationship (Type, Print) Address Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ridgefield Circle, Frederick, MD21701 (Grandson) Eric R. May Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Lutheran cemetery 1/26/2010 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 1 XBurial Middletown, 4 Donation neral Service Signature of Fu Donald B. Thompson Funeral H POB 18, Middletown, MD 21769 1 Ener the disease, or comp ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a conseque *Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be e within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the buring Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of perform death? 2 🗆 No 1 Yes Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 lX No Certificate: To 1 Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Investigation
6 Could not be Accident 1 Yes 2 No 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) termir Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Wedical Aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of ertifie 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Pring 3 400 434. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Kobert TOFFISOR January 2010 11:30 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 612 Washington Road Westminster Carrol] 8. Date of Birth (Month, Day, Mar 25 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 🕱 M 2 🗆 F Months Hours Min. Yrs. Director 170–16–7404 89 Pennsylvania Usual Residence of Decedent 28a-f show 10b. County 10a, State notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 ☐ Yes 2 🛶 No Carroll Westminster 10e. Street and Number 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 612 Washington Road 21157 United States items filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Black, White, etc. ò þ 1 Never Married 2 Married 1 XYes 2 No If Yes, Give Year or Dates.1942— Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" Specify. Completed 3 Divorced White 45 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. d other than " event, the Mer life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Engineer Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked or r traumatic ever မ John permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic ones. Byron Morrison Evelyn Milks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonny Dudash/daughter 2010 Arabian Drive Finksburg, Maryland 21048 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 1/29/2010 Woodbine, Maryland 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 ianta M00957 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ etastati ancreatic disease or condition MUNTI Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, he find the first cause. Enter Underlying Cause (Disease or linjury Due to lor as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed and tran that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burlal-1 Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day Pregnant at time of death 5 Other (specify) ed by the a detached f 2 No g Unknown g Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed page 2 should peen . Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy Yes 2 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 X No ဂ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA nin 24 hours after death. the Funeral Director: After this on pleted filled in by the funeral directions. 4 D Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 \(\subseteq \text{Yes} \) Accident Suicide 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

State Registrar

Medical

29a. Certifier

(Check

only one) 29b. Sign

31. Date filed (Month

2 L 3 L

n, Day, Year) JAN2

within 2 To the

30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

Charles St. Baltimore

OMCOLOGIS 7

egistrar's Signature

1. Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

00056919

29d. Date signed (Month, Day, Year)

71204

01/28/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Doretha B. Morten 01-29-2010 Medical 16:47 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 🔀 F Months Hours 577-70-0272 Director 01-16-1931 59 Washington, DC Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho **Funeral Director** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Silver Spring 1 ሺ Yes 2 🗌 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 12325 New Hampshire Avenue 20904 U.S.A. "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 X Never Married 2 Married þ Black, White, etc. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Completed 3
Widowed 4 Divorced Specify Specify: Black item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12th College (1-4 or 5+) Residential Manager Apartment Building Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hugo Minor Peggy Morten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Morten (Son) 1302 Saratoga Ave. N.E. #1 Washington, DC 20018 20a. Method of Disposition
1
Burial 2
Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Chesapeake Crematory 02/04/2010 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 13 of Hun ral Service 22. Name and Address of Facility W.H. Bacon FuneralHOme, Inc. any 14th St. N.W. Washington, DC 20010. A. Enter the disease, or complications that caused ck, or heart failure. List only one cause on each line. that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final √ Ilysician/ Opert and Death Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Pneumonia Days Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physician and I for use as the burial-transit death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) ate has been signed by the atte page 2 should be detached for in the past 12 months? Ectopic pregnancy Pregnant at time of death 1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 23e. Did tobacco use contribute to the cause of death? Completed End stage renal disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 X 2 💹 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director; Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🔀 No 은 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Accident Investigation 1 ☐ Yes 2 ☐ No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

9801 Georgia Avenue suite#220

32. Registræ's Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suresh K. Gupta

31. Date filed (Month, Day, Year,

D 32332

01 - 30 - 10

Silver Spring, Maryland 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Marti 2010 15A M Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** esaPeake ambri 29 Dorchester loods Nursina 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. **Funeral** 1 □ M 2 🖫 F Director Maryland Usual Residence of Decedent items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No 10e. Street and Number 10f. Zip Codf 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. ō 1 Never Married 2 Married þ 72 hours after Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates "natural", 3 - Widowed 4 Divorced Black Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) ၉ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. UV 19a. Informant's Name/Relationship (Type, Print) + Maryland21643 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 PBurial 2 Cremation 3 Removal from State 12010 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Funeral ! Henry 5+ 23a. Part. Enter the disease, or complications that caused the coath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final c Physician/ disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner enav Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): and I-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No the a 9 Unknown 9 Unknown is been signed by the should be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Number Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy page 2 **A** No ☐ Yes Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) funeral director, Hospital 2 1 No 유 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 5 Pendino death. 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director: completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) D69234 1 N 20/0 30. Name and address of persop who completed cause of death (Item 23a) (Type, Print) 21613 CAMBRIDGE, JEEVAN ERRABOLU, MD 503 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month CAROLYN J. MURRAY Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9 WICOMICO 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗷 F Months Hours Min. (Month, Day, Year) 8/8/1948 MARYLAND Director 61 214-46-4086 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MARYLAND DORCHESTER **CAMBRIDGE** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 208 OAKLEY ST. 21613 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **OWNER** FOOD SERVICE 12 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ CHARLES W. TODD GLORIA JUNE DEAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 OAKLEY ST., CAMBRIDGE, MD 21613 RICHARD W. MURRAY / HUSBAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MID SHORE CREMATION CENTER 2/1/2010 CAMBRIDGE, MD 21. Signature of Fun 22. Name and Address of Facility MID SHORE CREMATION CENTER, 2272 HUDSON RD., CAMBRIDGE, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ekis Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leaving to immediate cause. Enter Underlying Cause (Disease or iinjury Due to joi as a consequence oil To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physiclan: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Month Day Year 5 Other (specify) Yes 2 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy perform 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 X No 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) Hospice မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending ☐ Accident Investigation within 24 hours after deat To the Funeral Director. Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 01-31-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

FEB 0

32. Registrar's Signature

GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, M.D. 21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Thai 8:01ам Hoa Nguyen anuaru Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital <u>Rockville</u> <u>Montgomery</u> If Under 24 Hrs Hours Min. Social Security Number . Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Vietnam 1 □ M 2 🗓 F Davs 12/1-17/1917 Months Director 586-32-2939 Usual Residence of Decedent permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "----10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomeru Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19678 Club Lake Road 20886 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian. Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give 1 Never Married 2 Married ð 1 Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed Asian Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Van Luu Nguyen An Thi Nauyen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tam Duy Nguyen - Son West Stanhope Road. Kensington, Maryland 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 02/01/2010 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Lin nsee m00709 11800 New Hampshire Ave., Silver Spring. MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Acute Heart Attack Medical , Medical Examiner Due to (or as a consequence of) Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of, attending physician and I for use as the burial-transi Cause (Disease or iinjury Anemia that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis Failure to Thrive Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) Yes 4 ☐ Pregnant 9 ☐ Unknown been signed by the s g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an completed filled in by the funeral director, page 2 autopsy performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 X No Other: 1 X Inpatient 2 - ER/Outpatient 3 - DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?

1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury X Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Medical 29a. Certifie 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 To the I only one

State Registrar 29b. Signatur

31. Date filed (Month,

30. Name and address of person who

completed cause of death (Item 23a) (Type-Print)

700 2527

Rani R. Emad, M.D.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene n L 30 State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Year Martha DuVerger 2010 Medical Tanuary 2:30 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sunrise Assisted Living Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 29, 1926 6. Se: 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Months Davs Hours Director 215-20-4129 83 Washington, DC Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits Director ms 23a or 28a-f s must be notified 1 Yes 2 XNo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15301 Wallbrook Court Apt 3F 20906 United States items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. 5 þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Specify. "natural" Completed 3 ₩ Widowed 4 Divorced Year or Dates White other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Program Analyst Healthcare/Research Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Francis DuVerger Ann Borton Byrnece nt of Health and It if item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Clark/daughter 21137 Los Cabos Court Land O Lakes, Florida 34637 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ö 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 1/27/2010 Woodbine, Maryland . Sign P re of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M Thomas M00957 MD 21029 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pilysician/ Non small cell lung cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a conseductice of sician and burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 as the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy for in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Day 1 Yes 2 No signed by the a d be detached f a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 X Unknown Completed 1 Yes page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐xNo Assisted Other: 4 Nursing Home 5 Residence 6 X Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this Livina 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 \square Pending injury 1 ☐ Yes 2 ☐ No 2 ☐ Acciderii 3 ☐ Suicide 4 ☐ Homicide Accident Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

DHMH 17 Rev 7/2009

Registrar

State

Medical

29a. Certifier

31. Date filed (Month.

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatur

with the last

Christopher J. Mays, M.D.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D39793

18111 Prince Philip Dr. Suite 207 Olney, Maryland 20832

29d. Date signed (Month, Day, Year)

January 25, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For AMEND#5 per FH State of Marylar State Registrar2/4/2010 AACO HEALIH DEPT. CMH Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 26 Month Physician January Pearl C. Owens 2010 4:10 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 130 Hearne Rd. Apt 408 Annapolis 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day June 5 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1940 Months Days Hours Min. Maryland 1 □ M 2X F $219 - \frac{78}{78} - 7685$ 69 Yrs June Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No event, the Medical Examiner must be notified Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 130 Hearne Rd. USA Apt 408 21401 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 M No If Yes, Give or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: Specify: Black ð 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 'natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Director I Hygiene. Future Care Elementary/Secondary (0-12) College (1-4or 5+) 12th 4yrs Environmental Services Nursing Home marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental em 27 is marked o Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. Isaac Johnson Ruth E. Thomas ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaVona Cooper(Daughter) <u>3485 Harper Lane</u> Rex, Georgia 30273 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 1 - 27 - 10Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Emame Leads G of & cilis ons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, MO045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to r as a consequence of) **Examiner** Sequentially list conditions, if any, leading to infinite liable cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed y physician and is the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ∐Yes 2 No 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1√10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral I Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 MI 53306 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sto 300 Annapolis 900 Bestgate Curtis Varres

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Morth, Day, Year)

JAN 28 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State State Registra MFND#7perFH, 1/28/10, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Craemer Virginia 01er 21, January 2010 2:45 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maplewood Assited Living Bethesda Montgomery 8. Date of Birth (Month, Day, Year) Aug 3,1923 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 198-26-5188 87 Flushing, NY Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, tra Medical Examinar must be notified at 1.□Yes 2□No Director MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9707 Old Georgetown Rd, #118 20814 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian should be filed within 72 hours after nd Mental Hygiene. marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify White þ 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Physician Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fill h and Mental H 'is marked oth Be William Craemer Louise Anger ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Pages 1 and 2 si partment of Health an portant; If item 27 is 1 y Injury or other traur Stephen Oler/Son 81 Monadnock Rd, Wellesley, MA 20481 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page Department of Important; If any Injury or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 - 29 - 10National Crematory Falls Church, Va 5 ☐ Other (Specify) 4 Donation 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Juneral S. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last omentic Examiner Due to (or as a consequence of): buriaf-1 attending physician for use as the burial Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the 9 Unknown à signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy certificate 1 ☐Yes 2 XNo 1 ☐Yes 2 ☐No director 25. Was case referred to medical Be 26. Place of Death (Check only on) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed Box 68760. P.0. Division of Vital Records,

Baltimore, Maryland 21215-0036

To the Hospital or Attending thin 24 hours after death.

the Funeral Director: A suppletely filled in by the fu within 2, To the F complet

> State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 Old Georgetown Rd, Bethesda, MD 20814 Merlyn Vemury, M.D.31. Date filed (Month, Day, Year)

JAN 28 2010

determined

4 Homicide

29b. Signature and title of certifier

29a. Certifier (Check only

0

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 35791

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Gilbert Eugene Peaks 12:10 P M Medical 20104a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Bir.. Day Y **Funeral** 1 M 2 D F Days Months Hours North Carolina 244 42 7706 77Yrs Director March Usual Residence of Decedent ir than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's 1 Yes 2 No Temple Hills 10f. Zip Code 10g. Citizen of What Country? Funeral 5601 Chesterfield Drive 20748 United States 72 hours after death Was Deceou... Armed Forces? 1 M Wes 2 No 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 African American 1 ☐ Yes 2 🔀 No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Respiratory Therapist Medical Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname, and Mental H 2 Department of Health and Menta Important: If item 27 is marked any injury or other transpore. Otis Peaks Annie Mae Street 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance Peaks (wife) 5601 Chesterfield Drive, Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory Jan 28, 2010 Clinton, Maryland 21. Signatur vot uneral Serv 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 04 6. Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, o heart fulure. List only one cause on each line Immediate Cause (* mail disease or condit resulting in death Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of, -transit or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): use as the burialthe attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE; 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ fo in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year should be detached g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perform within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag shock Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 📉 No Hospital Other: 욘 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury 27. Manger of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010

BUS+1 State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VANIKAR

N

		1 - State Registra MEN	D#20bper	TH,1/29/10	,BMW,	MbCo	Cei	rtificat	e of	Death		
Physicia	n	1. Decedent's Name	e (First, Middle	e, Last)								2. Date of De Month
/Medic			George	e Robb	ins	P	orter					January
Examin		4a. Facility Name (I	f not institution	, give street and nu	ımber)			4b. City,	Town, o	r Location	of Death	
		Shady Gr	ove Adv	entist H	ospi	tal		Ro	ckvi	11e		
Funeral		5. Social Security N	umber	6. Sex	7. Age	(In yrs. la	ast birthday)	If Under		If Under	24 Hrs. Min.	8. Date of Bir (Month, Da
Director		578-58-76	586	1 X M 2□ F		94	Yrs.	Months	Days	Hours	MIII.	Sept.27
D		Usual Residence of	Decedent									
rylan how	_	10a. State	10b. County			10c. City	, Town or Lo	cation				
a-f s	Director	Maryland	Mont	gomery		Ga	aither	sburg	5			
# 80 H	<u>i</u>	10e. Street and Nur	nber					10f. Zip	Code			
th with		419 Russ	ell Ave	enue, #31	3				2087	7		
filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, Item Acaminer must be notified at	by Funeral	11. Marital Status 1 □ Never Marri 3 □ Widowed		12. Was Dec Armed Fo ied 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	orces? 2 □ No ive			Was Deced fYes, spec I□Yes	cify Cuba	lispanic Or an, Mexica Specify	n, Puerto	pecify Yes or No Rican, etc.)
72 ho	leted	(Spec	15. Decedent	's Education et grade completed)			16a. Deced	kind of wo	rk done	durina mos	st of work	ing
within jene. than	Completed	Elementary/Seco	ndary (0-12)	College (-)		sonne		•	or	
be filed trial Hygist d other event, tr	Be C	17. Father's Name ((First, Middle, I									e (First, Middle,
ا موريخ ت	6 B	F	Harry	н. н	ort	er						France
sho and t ma uma		19a. Informant's Na	ame/Relationsh	nip (Type. Print)			19b. Mailir	g Address	(Street	and Numb	er or Rui	ral Route Numb
E ST in the state of the state		Billie Le	e Port	er/Spouse	2		419 R	usse1	1 A	venue	, #	313, Ga
f He item oth		20a. Method of Disp		-		20b. Pl	ace of Dispo	sition (Nar	ne of	i		Date
Pages 1 a ment of Hea ant: If item ury or othe		1⊠ Burial 2 ☐ 4 ☐ Donation		3 Removal from	State		metery, cren klawn	•		. '	2-2-	2010
- Ē tā 5		4 L Donadon	2 House (2)	Jeony)		rall	Lawii	riell.	rall	r i	1/40	/ 4010

10d. Inside City Limits 1X Yes 2 □ No 10f. Zip Code 10g, Citizen of What Country?

20.

Year) 1915

2010 4c. County of Death Montgomery

United States

14. Race - American Indian.

Ostrander

9. Birthplace (State or Foreign Country) New York

Black, White, etc. Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry

Federal Government 18. Mother's Name (First, Middle, Maiden Surname)

Η. Porter Harry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Billie Lee Porter/Spouse

419 Russell Avenue, # 313, Gaithersburg, MD. 20877

Frances

20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/26/2010 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Mem. Park Rockville, Maryland

22. Name and Address of Facility DeVol Funeral Home 21 Signature of Funeral Service Licen

10 East Deer Park Dr., Gaithersburg, MD. 20877

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final a Acute Pulmonary Embolism disease or condition resulting in death) Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Department of Health Important: If item 27 any injury or other trong once.

Physician

/Medical

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Box 68760,

P.0.

Division of Vital Records,

Examine

Physician/Medical

Completed by

Be

Medical Certification: To

29a. Certifier

(Check only

Baltimore, Maryland 21215-0036

b. Aspiration Pneumonia Due to (or as a consequence of)

Due to (or as a consequence of):

25. Was case referred to medical

IF FEMALE:	
23b. Was decedent pregnant	2
in the past 12 months?	
1 ☐ Yes 2 ☐ No	
9 Unknown	

3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death

3 Ectopic pregnancy
5 Other (specify)

23d. Date of delivery Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23	e. Did tobac	co use con	tribute to the cau	se of death?
	1 🗆 Yes	2 🔀 No	3 ☐ Probably	4 🗌 Unknov
Acres on				

Dementia

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 TVNo	1 ☐ Yes 2 ☐ No

(Specify)

Year

Hospital: 1 2 1 Tes 2 No 27. Manner of Death 28a. Dat 1 X Natural 5 Pending investigation 2 ☐ Accident

Inpatient	2 🗆	ER/Outpatient	3 🗆 [OOA	Other: 4	er: 4 🗆 Nursing Home		5 Residence	6 ☐Other
te of Injury onth, Day, Yea	ar)	28b. Time of Injury		28c.	Injury at Work?	0 DN:	28d.	Describe how inju	ary occurred

D 62435

6 ☐Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

	building, etc. (Specify)	City or Town, State)
I X Certifying Physic	cían: To the best of my knowledge, death occurred at the time, date and place	e, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number,

January 20, 2010

	one)	ar	nd manner state	d.	
29b.	Signature and title of certifier			5	
		1	7	1000	1

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month. Day, Year)

26. Place of Death (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10110 Molecular Drive, Rockville, Maryland 20850 Sayed Elsayyad, M.D.

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

within 24 hours aner used. To the Funeral Director: Aff

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thomas Arthur Probey January 2010 10:52 aM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mon toomery Suburban Hospital Bethesda Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Hours July 21, Year 1935 Director 74 D.C. 577-46-7864 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar most han activity or other traumatic event, the Medical Examinar most han activity or other traumatic event. if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 ☐ Yes 2 No Kensington Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20895 11111 Lund Place Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc. White Completed by 1 Never Married 2 Married ^{2 1}1960-63 Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Comptroller Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Evelyn Wooden William Robert Probey 19a. Informant's Name/Relationship (Type, Print)
Marie S. Probey/ Wife 19b, Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11111 Lund Place, Kensington, MD 20895 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Jane 31, 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State cemetery, crematory or other place)
Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licenses ² Name and Address of Ecolopius Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 2090 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Myocerchal Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Stenosis Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Probey: Thomas IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed Yes 2 X 25. Was case referred to medical examiner? Certificate: To Be 26. Place of Death (Check only one) 2 No Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Division of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completed filled in by the fu Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) Jermery, 29, +1 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

FEB 03

8600 old Georgetown Rel, Betherly, MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For 1 _ State	State of Mar				Mental Hyg	iene	01.207
			Registrar 1. Decedent's Name (First, Middle)	la Last)	Ce	rtificate of	Death	2. Date of Deat	eg. No. C U I U	04307
	Physici /Medi		Vera	Petkoff				Jan. 27	, 2010 Year	3. Time of Death 4:25a M
1	Examir	er	4a. Facility Name (If not institution				r Location of Death		4c. County of Dea	
			Ft. Washingto 5. Social Security Number		Rehab.		shingto			George's thplace (State or Foreign
	Funeral Director		132-24-4244	1 M 2 🙀 F	96 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,		ountry)
			Usual Residence of Decedent		<u> </u>			!/24/	1914 RU	ıssia
	arylan show	_	10a. State 10b. County		0c. City, Town or Lo					10d. Inside City Limits
	8a-f	ecto		ce George's	F't.Wa	shingto	n 			1 ☐ Yes 2 🛣 No
	with t	宣	10e. Street and Number 12812 Pine	Tree Lane		10f. Zip Code 2079	1	10	0g. Citizen of What Co USA	ountry?
	ms 23	ıera	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.			pecify Yes or No-	14. Race - Ame	erican Indian,
9	urs after death with the Marylan al", or items 23a or 28a-f show Examer must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Mar	Armed Forces? ried 1 □ Yes 2 □ No			Hispanic Origin? (Span, Mexican, Puerto	o Rican, etc.)	Black, Whit	e, etc.
003	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show offical Examiner must be notified at	d by	3 Widowed 4 ☐ Divorced			1 □Yes 2 🙀 No	Specify:		Specify: W	hite
15		lete	15. Deceden (Specify only highe	t's Education st grade completed)	16a. Dece	dent's Usual Occup kind of work done	oation during most of work d)	king	16b. Kind of Business	'Industry
212	within jiene. r than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Eco	onomist	۵)		American	Express
br	al Hyg other	Be C	17. Father's Name (First, Middle,	Last)				ne (First, Middle, M	,	
ylar	Menta	To	Roman Pshes	lavsky			Olga E	Sheslav	vsky	
Maryland 21215-0036	2 sho	C T	19a. Informant's Name/Relations Olga Shishke		1 1	-			City or Town, State,	
	1 and Health em 27 ther t		20a. Method of Disposition		20b. Place of Dispo				Vashingto 20c. Location - City or	n, Md20744
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monce.	1 5	1 ☑ Burial 2 ☐ Cremation	Removal from State	Novo-Dix	natory or other place	^{ce)} issian		ŕ	
Ħ	nit. Partme artme ortan injur	1	4 ☐ Donation 5 ☐ Other (S	-/	Ortho.Co	onvent (Cem 1/30)/2010 L	Nanuet, N AL SERVI	lew York
B	Depar Impo any ir	()()	Meg Uxa	int						ng,Md20910
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that caused the only one cause on each line.	e death. Do not ent					Approximate Interval Between
N.	Physician	r n	Immediate Cause (Final disease or condition		scleroti	ic Cardi	ioVascul	ar Dise	ease	Onset and Death 4yrs
	/Medical Examiner		resulting in death)	Due to (or as a c	consequence of):					•
		er	Sequentially list conditions,	b Due to for es air	ronsacuanna ofi:					
R	outed d ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events		,					
4,	e exec ian an ırial-tr	Exa	resulting in death) Last	Due to (or as a c	consequence of):					
8760	cate be executed physician and the burial-transit	dical		d						
9 ×	ertific ding p	/Мес	IF FEMALE:	000 16						
Вох	eath certific attending p for use as	cian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at til	☐ Fetal death 3 ☐	Ectopic pregnanc	;y		23d. Date of de Month	livery Day Year
0	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	1 □ Yes 2 ☑ No 9 □ Unknown	9 Unknown	ine or death 5 E					
ω, σ.	iires that signed b d be deta	by Pt	Part II. Other significant condition	ons contributing to death but r	not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ord	w require s been siç should b	ed k			-	-		1 □ Ye	s 2⊠No 3□P	robably 4 🗌 Unknown
Records,	law ri nas be	Completed						24a. Was ar		utopsy findings available completion of cause of
E H	ician: The lav certificate has ector, page 2.	Con						perform		
Vit	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		oth Oth	or:	th (Check only one	· 	
of	Phys er this eral dii	5. To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatier 28b. Time of	IL 3 DOA	4 X Nursing m	ome 5 Reside	nce 6 Other (Spe	ecify)
ion	nding tth. :: Afte e fune	atior	1 Natural 5 Pendin 2 Accident Investio	g (Month, Day, Y	<i>(ear)</i> Injury	Worl	ḱ? Yes 2 □No	200. 2000/150 110	w mjary occarros	
Division of Vital	· Atter	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ		- At home, farm, stre	eet, factory, office		28f. Location (Str. City or Town	reet and Number or Ri	ural Route Number,
Ö	ital or irs afte al Dir led in	Cert	T E Homoldo	building, etc. (City of Town	, Siale)	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical		ng Physician: To the best of r Examiner: On the basis of ex	xamination and/or in					
	o the vithin 2 o the omple	Med	29b. Signature and title of certifier	and manner state	d.	29c. Licens	e number	29	9d. Date signed (Mont	h, Day, Year)
	2		· nlit		-		545		Jan.29,	
		}	30. Name and address of person	who completed cause of deat						
			Philip Wits	-		Line C	enter W	aldorf,	Md 20662	
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	2010 3. Registrar's		Plant .				
	riegisti	.11		LUIU PERME	158 . 25 10 500	O Tagging and the Control of the Con				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joseph Loran Perritte January 30, 2010 Year 9:45 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Mon top mery Social Security Number 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 🖾 M 2 🗆 F Country) **Texas** Director 466-24-2125 Usual Residence of Decedent ral", or items 23a or 28a-f shor Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 🗌 Yes 2 🎦 No Silver Spring Maryland Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20902 3946 Rickover Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. þ 1 Never Married 2 Married 1X Yes If Yes, Give 2 🗌 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Year or Dates. 1944-46 Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) uth and Mental Hygiene. 27 is marked other than "Ir r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) FBI Special Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important. If item 27 is marked o any injury or other traumatic eve ည Thomas Jefferson Perritte Luby Judson Balch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3946 Rickover Road, Silver Spring, MD 20902 Romayne Bell Perritte/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Feb. 4 Gate of Heaven Cemetery Silver Spring, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Metastatic Prostate Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Due to (or as a soline-queries of): ng physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 夕 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pagr 1 ☐ Yes 2 ☐ No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No ပ Inpatient 2 - ER/Outpatient 3 - DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 🛚 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Our liftying Nurse Prenticeor. To the best of my knowledge, deeth consend at the time, detalend alere, and due to the manuals) and manual as state 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sujoy G. Tagore, MD 8600 Old Georgetown Road, Bethesda, MD 20814

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

FEB 03 2010

ack

2. Registrar's Signature

Physician /Medical Examiner
Euparal

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Phys /Me Exa

Division of Vital Records, P.O. Box 68760, 🦙 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

	= State Registrar			Cer	tificate of	Death		F	Reg. No. 2010 0430					
	1. Decedent's Name (First, Middle Warren F. Phely							2. Date of Dea Month January	th	20 1 0	3. Time of Death 2:20A. M			
al er 4	4a. Facility Name (If not institution Shady Grove Adv	n, give street and nu			4b. City, Town, C		f Death	Janaar	4c. Co					
5	5. Social Security Number	6. Sex	7. Age (In yrs.	_	If Under 1 Year Months Days	If Under 2	24 Hrs. Min.	8. Date of Birth (Month, Day June6,		ntgomer	place (State or Foreign intry)			
<u> </u>	215-14-7166 Usual Residence of Decedent	1₩ 2□F	3	37 Yrs.				June6,	1922	Wasi	nington,DC			
.	Maryland Prince	_		y, Town or Loc tsvill	е						10d. Inside City Limits 1 □Yes 2 🛣 No			
	10e. Street and Number 13118 Oriole Dr	ive			10f. Zip Code 20705				_	n of What Cou d State				
2	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	ried Armed Fo	2 □ No ve th7777	. .	Vas Decedent of l Yes, specify Cub □Yes 2 No	Hispanic Orig an, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)		Black, White,	Race - American Indian, Black, White, etc. ecify: White			
Completed	15. Deceden (Specify only highe	it's Education st grade completed)		(Give	ent's Usual Occu	during most	of workir	ng I	16b. Kind	of Business/Ir	ndustry			
dulo	Elementary/Secondary (0-12)	College (1-4or 5+)		$1 { m igence}$		er]	eder	al Gove	vernment			
D 1	17. Father's Name (First, Middle, Spencer W. Phel			18. Mother's Name (First, Middle, Maiden Surname) Mary Edna Nalley										
-1.	19a. Informant's Name/Relations Nancy Lee Brads		ghter		g Address <i>(Stree</i> Arada C									
2	20a. Method of Disposition 14 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery, 1/29/2010 Brentwood, Maryland													
aminer	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Onset and Death Due to (or as a consequence of): Sepsis Due to (or as a consequence of): Renal Cancer Due to (or as a consequence of):													
Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	tcome of pregna birth 2 ☐ Feta nant at time of c	Ideath 3□	h 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)					d. Date of deli	very Day Year			
<u>`</u>	Part II. Other significant condition Prostate Canc	Ü		not resulting in the underlying cause given in Part I. Dementia					. Did tobacco use contribute to the cause of deat 1 □ Yes 2ሺ No 3 □ Probably 4 □ Unku					
Completed								24a. Was a autop perfor	topsy prior to completion of cause of rformed?					
e a	25. Was case referred to medical examiner? 1 ☐ Yes 2 🕅 No		Inpatient 2		Ot	oer:		(Check only or		700 15				
ation: lo	27. Manner of Death 1 ZNatural 5 Pendin 2 Accident investi	28a. Date	28b. Time of Injury	28c. Inju	ry at	2		idence 6 Other (Specify) how injury occurred						
Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		eet, factory, office	2	28f. Location (S City or Tow	tion (Street and Number or Rural Route Number, or Town, State)								
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
	29b. Signature and title of certifie	_			29c. Licen	180		29d. Date signed (Month, Day, Year) 01/27/10 .						
5	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sireesha Jalli, M.D. 9901 Medical Center Drive Rockville, Maryland 20850													
	Sireesha Jalli	M.D. 99	()1 Media	cal Cer	iter Driv	re Rom	kvi l	le. Mar	vland	1 20850	1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John Alexander Pekar January 25, 2010 9:18 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 9307 Adelaide Drive Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign July 9, 1934 1 M 2 D F Months Pennsylvania 175-26-1101 75 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits with the Maryland Director 1 ☐ Yes 2 🏝 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9307 Adelaide Drive 20817 USA death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was December 4 Armed Forces?

★★ Yes 2 □ No
If Yes, Give Korean
Year or Dates Conflict Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene.
77 is marked other than "I Elementary/Seconday (0-12) College (1-4 or 5+) 5+Patent Examiner U.S. Patent Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Pekar Salomea Blazejewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heath ar Important: If item 27 is any injury or other trau Marca V. Pekar/Wife 9307 Adelaide Drive, Bethesda, MD 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State Jan. 2010 26 Metropolitan Crematory 4 Donation 5 Other (Specify) Alexandria, Virginia ²² Name and Address of Facility ins Funeral Home Inc 21. Signatur Funeral_Service Lice 500 University Blvd. W., Silver Spring, MD 2090 23a. Part 1. Enter the disease, or compleshock, or heart failure. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer cause on each line. Immediate Cause (Final Onset and Death
Years Physician/ Non-Small Cell Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate
Cause (Disease or linjury Due to (or as a consequence of): ending physician and use as the burial-transit or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ρ Other (specify) Month Day Year Pregnant at time of death the detached 9 Unknown 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 🔀 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 A No certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 S Residence 6 Other (Specify) 1 XYes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature title of certifi 29c. License number 29d. Date signed (Month, Day, Year) D29675 January 26, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Ralph Boccia, MD

28

31. Date filed (Month, Day, Year)

Registrar's Signature

6420 Rockledge Drive, Bethesda, MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2^{Day} Month 1 2010 **Physician** 5:50 A M Odetta Ellen Perdue /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Atlantic General Hospital Worcester Berlin If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Ye 1/9/1931 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 Ϊ F 79 MD 222-18-6330 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marical Expiriting is used to notified at once. 1 ☐ Yes 2 XNo Director Worcester Snow Hill MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21863 USA 4712 Washington St. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🔀 No o / /ユノ/ュゥ/o Maryland 21215-0036 1 □Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Administrative Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eva Morris Horace R. Cropper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5 Cormack Ct., Reisterstown, MD 21136 Sara L. Martin / daughter timore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 0 20a. Method of Disposition 0 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/30/2010 Whatcoat Cemetery Snow Hill, MD a A 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Fune Service Licens 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on an line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician chronic obstructive disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner aate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No certificate Division of Vital i or Attending Physician: after death.

Director: After this certifice 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DUUS4307 mnegmonel anwary 27,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Van Egmund MD, Atlantic General Hospital, 9733 Healthway Drive, Berlin, MD 24811 31. Date filed (Mon State parks Registrar

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	1 State Registrar	l act)		Ce	rtificate of L	Death		Reg. No.2	<u>U I O</u>	0431		
in/	1. Decedent's Name (First, Middle, SUNICE TO	^	ER				2. Date of Dea Month	Day Z-6	2-0/U	3. Time of Death		
er	4a. Facility Name (if not institution,				4b. City, Town, or	Location of Death		4c. Co	ounty of Deat			
	11131 Willow Bo					olumbia		F	loward			
	059-28-7138	5. Sex 1 □ M 2 X F	ge (In yrs. Ia 74	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl April	6,193	9. Birt	hplace (State or Fore New York		
ţ	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	ocation					10d. Inside City Lim		
Director	Maryland Howar	rd	<u> </u>	Co	lumbia 10f. Zip Code			10a Citize	n of What Co	1 Yes 2 X		
Funeral	11131 Willow Bo	ottom			2	1044			ted St			
Ē	11. Marital Status	12. Was Decedent			Was Decedent of H	spanic Origin? (Spe	cify Yes or No-		. Race - Ame			
	1 Never Married 2 🔀 Marrie	Armed Forces? 1 Yes 2 If Yes, Give			If Yes, specify Cuba 1 ☐ Yes 2 🛣 No		Hican, etc.)		Black, White			
Completed by	3 Widowed 4 Divorced	Year or Dates.						Sp	ecify:	White		
롈	15. Decedent (Specify only highes	t grade completed)		(Give	dent's Usual Occup kind of work done o OO NOT use retired)		ing	16b. Kind	of Business	industry		
ខ្ញុ	Elementary/Seconday (0-12)	5+)		nool Psych	ologist			Education				
Be	17. Father's Name (First, Middle, La	5+_ st)		DCI	loor rayer	18. Mother's Name	e (First, Middle, I	Maiden Sur		acton		
일	Herbert Jo	У			Mari	ion He	reber	:t				
	19a. Informant's Name/Relationshi	o (Type, Print)		19b. Maili	ing Address (Street a	and Number or Rura	l Route Number	City or To	wn, State, Zip	Code)		
	Cyril B. Paumie	er/husband		1113	31 Willow	Bottom Co	olumbia,	Mary	land 2	21044		
	20a. Method of Disposition	B Removal from State		lace of Dispe	osition (Name of matory or other place	e) [Date	20c. Loca	tion - City or	Town, State		
	4 Donation 5 Other (Specify) Final Journey Crematory 1/30/2010 Woodbine, Maryland											
	21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M											
Ш												
	23a. Part III. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final									Approximate Interval Between Onset and Death		
	disease or condition resulting in death)	a	STATIC	Lu	my CANE	on				345		
	,	Due to (or as	a consequ	ience of):	MUCHATZI	10051710				zins		
Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	,		1100000120	Car-Cycs				- 9		
Examine	cause. Enter Underlying Cause (Disease or iinjury								ŀ			
Ĕ	that initiated events c. Due to (or as a consequence of):											
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Physician/Medic	IF FEMALE:											
ian/	23b. Was decedent pregnant in the past 12 mgnths?		2 Feta	Ideath 3	Ectopic pregnanc	у		230	d. Date of del			
ysic	1 ☐ Yes 2 🗹 No 9 ☐ Unknown	4 ∐ Pregnant a 9 □ Unknown	at time of d	leath 5 l	Other (specify)		Month			Day Year		
	Part II. Other significant condition	23e. Did tobacco use contribute to the cause of death?										
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Completed							24a. Was a	ın 2	24b Were aut	opsy findings availab		
щ							autop perfor	med?	prior to death?	completion of cause		
Be C	25. Was case referred to medical				1 ☐ Yes 2 No 26. Place of Death (Check only one)					2 □ No		
To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ient 2 🗆	ER/Outpatie	nt 3 DOA Othe			ence 6 \square	Other (Speci	fv)		
	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of inju	ıry	28b. Time o		at	28d. Describe ho			· <i>y</i> /		
fica	2 Accident Investiga	ition	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	" i jui y		Yes 2 □ No						
Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine				reet, factory, office		28f. Location (Si City or Town		umber or Rur	al Route Number,		
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Medical	(Check 2 L Medical Ex	Physician: To the best of aminer: On the basis of a	examination	and/or inves	stigation, in my opinic	n, death occurred at	the time, date ar	nd place, an	d due to the o	ause(s) and manner s		
Š	only one) 3 L Certifying I	lurse Practioner: To the	best of my	knowledge,	death occurred at the 29c. License				igned (Month			
	I State 148	- alang			D 34.				> 20			
ı	- Wille	V John John John John John John John John	loath /Itom	23a) /Tvpe	\				/			
	30. Name and address of person w	no completed cause of a										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2/2/2010 Physician/ 5:45 Ам Lester Eugene Pruitt Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crescent Cities Nursing Home Prince George's Hyattsville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days 1 ፟ M 2 ☐ F Hours Min. Asheville, NC Director 245-40-4838 76 Usual Residence of Decedent 23a or 28a-f show ist be notified at 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Prince George's Laurel 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral permit, Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must I 20708 U.S.A. 13301 Adams Place, #103 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give 1953—16 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. δ 1 Never Married 2 K Married 1 ☐ Yes 2 X No Specify: res, Give Year or Dates. 1953-1955 Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Bus Driver Metro Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Beulah Mae Smith Sidney Lawrence Pruitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Pruitt-Culbreth / Daughter 2310 Cheverly Avenue, Cheverly, MD 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2/3/2010 Alexandria, Virginia Metropolitan Crematory 22. Name and Address of Facility 4739 Baltimore Avenue 21. Signature of Funeral Service Licenses Gasch's Funeral Home, PA Hyattsville, MD 20781 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
2 Months Immediate Cause (Final Physician/ Ampullary Adenocarcinoma Months disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): physician and s the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Por Month Year 4 Pregnant at time of death 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pulmonary Embolism 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No has 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directorial dir this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No X Natural 5 Pending Investigation 6 Could not be Accident 2 Accident
3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tit 29d. Date signed (Month, Day, Year) D25914 2/2/2010 れ、D、 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4409 East-West Highway, Riverdale, MD 20737 Allen J. Brimmer,

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) FEB 0.4 2010

21215-0036

Baltimore, Maryland

Box 68760

P.0.

Records,

of Vital

Division

32. Registrar's Signature

			Please	Type or Pri										
			For	State of Ma	aryland /		artment of H		and M	lental Hy	giene	20	10	04314
			State Registrar			tificate of L		Reg. No.						
	Physicia	ın/	Decedent's Name (First, Middle, Las Sharod	st) B			2. Date of Death Month 1 - 31 - 2010 3. Time of Death 1 3 2 5							
	Medic	al	4a. Facility Name (if not institution, give			P	orter 4b. City, Town, or	Leastion	of Dooth	1-3	$\overline{}$	c. County o	4 Do-Al	
	Examin	er	Prince George	-	tal		Chever		OI Death					eorge's
	Funeral		5. Social Security Number 6. Sec		(In yrs. last bin	thday)	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Bir	th		9. Birtl	nplace (State or Foreign
ķ.,	Director		267-22-2176 1 Usual Residence of Decedent	1 1 Month Pa	<u>~ 19</u>	25	FĬő	rida						
	and show at	٥	10a. State 10b. County		10c. City, Tow	n or Loc	cation							10d. Inside City Limits
	Maryla	rect	DC		Washi	ngt	ton						l	XXYes 2 ☐ No
	a or 2	i D	10e. Street and Number				10f. Zip Code				_	itizen of W	hat Cou	untry?
	th with	Funeral Director	5335 Astor Pla			1	20019					USA		
· ^	or dea		11. Marital Status 1 X Never Married 2 Married	12. Was Decedent E Armed Forces? 1 XYes 2	ver in U.S. 1944	13. V	Vas Decedent of His f Yes, specify Cubar	spanic Ori n, Mexicar	gin? (Spe n, Puerto f	cify Yes or No- Rican, etc.)			- Amer , White	ican Indian, , etc.
ğ	rs afte ural", Exan	ed b	3 🗆 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.	1946	1	☐ Yes 2 🙀 No	Specify.	:			Specify:	cify: Black	
2-0	2 hou "natu edical	plet	15. Decedent's Ed (Specify only highest gra		16a	(Give l	lent's Usual Occupa kind of work done d	lurina mos	t of workir	ng	16b. l	Kind of Bus	siness I	ndustry
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Maryland 21215-0036	Hygi othe	Be	17. Father's Name (First, Middle, Last)					18. Moth	er's Name	(First, Middle,	Maiden	Surname)		
ylar	d be f Menta arked atic e	욘	Sam Porter			lah	Porter							
Jar	2 should be filed within 72 hours after death with the Maryland that and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (7) Alma Harris Po											
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no L	Page 1 nent of ant: If it ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donator 5 ☐ Dether (Specific	Removal from State	comoto	n/ oron	natory or other place oln Ceme	eters	2-6-	2 010			-	Town, State
Baltimore,	permit. Page 1. Department of 1 Important: If it any injury or of		21. Signatus at Fuseral Service No. is							M 51c		ntwo		, Μα Funeral
ñ	F F F F F		1 as	KIL		Ho	me 1058	3 Mi	ddl	eport	Ln	Whit	te :	Plains Md
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	plications that caused ne cause on each ine	the death. Do r	not ente	r the mode of dying	g, such as	cardiac o	respiratory an	rest,			Approximate Interval Between
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لمب	Medical Examiner		resulting in death)	Due to (or as a	consequence	of):	J							
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	ਜ਼ਿਲ੍ਹ 6	 	resulting in death) Last	Due to (or as a	consequence	of):								
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ž po	e atter	Physician/Medic	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth							Month			Day Year
5	by th	Phys	9 🗆 Unknown	9 🔲 Unknown										
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	and the tri	Be C	25. Was case referred to medical			_	26. Pla	ice of Dea	th (Check		2 X N	o 1	Yes	2 □ No
VITAI	nysici nis cer i direc	To B	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 🏻 Inpatie	nt 2 X ER/O∪	tpatien	t 3 DOA Other	r: 4 🗆 Ni	ursing Hor	ne 5 🗆 Resid	dence 6	6 🗌 Other	(Specif	iy) .
o a	(fter th		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injur (Month, Day,	y 28b. 7 Year) i	Time of njury	28c. Injury work?	?		8d. Describe h	now injur	y occurred	1	
SIOI TOIS	death death stor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be		a. At home fo	rm atro		Yes 2 🗌	-	106 L		-1 11 1	D	1 Day da Marakara
DIVISION	after safter I Direct		4 ☐ Homicide determined	building, etc.		riii, Sile	er, ractory, office		4	City or Tow	n, State))	or Hura	al Route Number,
-	hours unera	Medical		sician: To the best of r										ed. ause(s) and manner stated.
7	To use nowpus or Attended Proyection. The law requires that the deam centricate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	Me	only one) 3 Certifying Nurs				eath occurred at the	time, date		, and due to the	e cause(s) and man	ner as s	tated.
, F	8 5 ≦ 5		29b. Signature and title of certifier				29c. License		201			te signed (Month,	∪ay, Year)
	10+1		30. Name and address of person who c	completed cause of de	ath (Item 23a) (Type. Pr	rint)	OT	105		1/31			
2	.011		ALI POURMAN		3001 F	-ps)	rint) PITAL DR)	CHE	VERLY	1	MD.	20	785
	Stat	е	31. Date filed (Month, Day, Year)	32. Régistra	's Signature	7					/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** Eileen F. Piper 0652 AM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore 8. Date of Birth (Month, Day, Year) 01/02/1929 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs **Funeral** Months Days Hours Min 1 □ M 280 F 81 218-26-3256 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be neithed at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐Yes 2 No **Funeral Director** MD Calvert Lusby 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 509 Bay View Drive 20657 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify. b White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Stenographer Courts 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Rooney Elton Anna Marie Friedel ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Laurence Daniel Mathias/Son 509 Bay View Drive, Lusby, MD 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 02/01/2010 Cheltenham, Maryland eral Se 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on a an line. Approximate Interval Between Onset and Death Immediate Cause (Final archova Scula **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown á s been signed to should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 🗌 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has bage 2 s autopsy perform deatn? 1∐Yes 2⊡Mo certificate 1 □Yes 2 ☑No this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours aft ie Funeral Di bletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

e and iddress of person who completed cause of death (Item 23a) (Type, Print)

2010

FEB 01

32. Registrar's Signature

Namuary 26, 2010

5601 Loch Raven Boulevard, Baltimore Maryland 21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** January 31 2010 Louis Radford Russell /Medical ility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner LAPLATA ENTER MEDICAL Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 □ F July 15,1946 Wash Director 63 62 8702 Usual Residence of Decedent 10d, Inside City Limits 10a. State 10c. City, Town or Location 28a-f shov 1√∑Yes 2 □ No and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f sh aumatic event, II a Pudical Examilian Director White Plains MD Charles 10g. Citizen of What Country? 10e. Street and Number 4692 Duley Drive 20695 USA Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ∏Yes 2 □ No If Yes, Give Year or Dates: 1966-68 1 ☐ Never Married Married 1 □Yes 2√□No Specify. Black ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Supervisor GSA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cornelia Scott Louis Russell ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai 4692 Duley Drive White Plains, MD 20695 Marva Russell/wife 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2-10-2010 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BRISCOE-TONIC FUNERAL HOME Lembruy Clouses & 10nce 402 2294 Old Washington Rd Waldorf, MD 20601 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disea e, or complications the caused the death. Do not entir the mode of dying, such as cardiac or respiratory a shock, or heart failure. List only one cause on vach line. Immediate Cause (Final disease or condition resulting in death) **Physician** 30 Minula /Medical Due | (or as a o nsequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Exhours after death.

Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Ď 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 □ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 8b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2

State Registrar

29d. Date signed (Month, Day, Year)

pleted cause of death (Item 23a) (Type, Print)

29b. Signature and title of confine

LAPLATA, MD 20646

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 22, 2010 3:32 p M Mark н. Richardson Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Takoma Park Washington Adventist Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Funeral (Month, Day Year) 1 🖾 M 2 🗆 F Months Days Hours Min. Ountry) 577-08-0621 43 196 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location death with the Maryland Funeral Director ems 23a or 28a-f sh r must be notified a 1 Yes 2 No Silver Spring Maryland Montgomery 10f. Zip Code 20901 10e. Street and Number 9027 Saffron Lane 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status ral", or iter Examiner Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after Black If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" 3 Widowed 4 Divorced er than "nature the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ulth and Mental Hygiene. 27 is marked other than r traumatic event, the Ma Elementary/Seconday (0-12) College (1-4 or 5+) Special Assistant D.C. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wendell H. Richardson Maxine I. Tyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9027 Saffron Lane, Silver Spring, MD 20901 Maxine I. Richardson/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery 20a. Method of Disposition Jan. 2010 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 2090 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ herosclerotic Cardiovascular disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any leading to in relationate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital r Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown To Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an death? performed' 1 Yes 2 No ours a er death.

eral Director After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou To the Funel completed fil 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 0 0 0 6 0 10 0 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 01-24-10 TAHMINA AHMED 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLUD 20903 831, Unisurity Sast Silver Spry MD 31. Date filed (Month, Day, Year) 82. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 - For State Registrar	State of Ma	ıryland / Dep <i>Ce</i>	partment of H ertificate of D			iene _{eg. No.} 201	0 04318			
1. Decedent's Name (First, Middle, L	ast) odes				2. Date of Deat	h	3. Time of Death 302 PM			
Medical Examiner 4a. Facility Name (if not institution, given			4b. City, Town, or	Location of Death		4c. County of De	ath			
Montgomery Count 5. Social Security Number 6.		ospital (In yrs. last birthday)	01ney If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Montgome g. B	ry Birthplace (State or Foreign			
Director 226-20-1322	1 □ M 2 💢 F 8		Months Days	Hours Min.	09/05/19	Year) 21 Ba	ltimore, MD			
Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L					10d. Inside City Limits			
MD Montgo	mery	Rockvill	e 10f. Zip Code		T	10g. Citizen of What (1 🔁 Yes 2 🗆 No			
the purpose of the pu	14304 Bauer Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-									
O E S O Name and A D Manufact	Armed Forces?		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☐ No	n, Mexican, Puerto		14. Race - An Black, Wh Specify:	nerican Indian, lite, etc. White			
within 72 hours after than "ratural"; of giene. 3 Midowed 4 Divorced 3 Midowed 4 Divorced 3 Specify only highest (Specify only highest 5 Company 6 Company 6 Company 7 Company 8 Company 8 Company 9 Company 10 Company 11 Never Married 12 Divorced 13 Widowed 4 Divorced 15 Decedent's (Specify only highest 16 Company 17 Company 18 Company 19 Company 10 Company 11 Company 12 Company 13 Company 14 Company 15 Company 16 Company 17 Company 18 Company 19 Company 10 Company 10 Company 11 Company 12 Company 13 Company 14 Company 15 Company 16 Company 17 Company 18 Company 19 Company 10 Company 10 Company 11 Company 12 Company 13 Company 14 Company 15 Company 16 Company 17 Company 18 Company 19 Company 10 Company 10 Company 11 Company 12 Company 13 Company 14 Company 15 Company 16 Company 17 Company 18 Company 19 Company 10 Company 10 Company 11 Company 12 Company 13 Company 14 Company 15 Company 16 Company 17 Company 18 Company 18 Company 19 Company 10 Company 10 Company 11 Company 12 Company 13 Company 14 Company 15 Company 16 Company 17 Company 18 Company 18 Company 19 Company 10 Company 10 Company 11 Company 12 Company 13 Company 14 Company 15 Company 16 Company 17 Company 18 Company 19 Company 10 Company 10 Company 11 Company 12 Company 13 Company 14 Company 15 Company 16 Company 17 Company 18 Company 18 Company 19 Company 10 Company 10 Company 11 Company 12 Company 13 Company 14 Company 15 Company 16 Company 17 Company 18 Compa		(Give	16a. Decedent's Usual Occup. (Give kind of work done of life. DO NOT use retired) Secretary / B		ing	16b. Kind of Busines				
DE STATE OF THE ST				18. Mother's Name	, ,	faiden Surname)				
To the two parts of the		19b. Mai	ling Address (Street a	Grace Th		City or Town, State, 2	Zip Code)			
Arthur Levin - F	ower of Att	orney 93	2 Ivy Mea			NC 27707 20c. Location - City	or Town State			
20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of Control		National	ematory or other place Cremator	01/2	6/2010	Falls Chu				
21. Signature of Funeral Service Life	see M	(01163 É	Name and Address 1091 R8	s of Facility el Funera CKVIIIe F	l Direc	tion Inc kville MD	20852			
232-Part 1. Enter the disease, or co shock, or heart failure. List only	mplications that caused one cause on each line.	the death. Do not en					Approximate Interval Between Onset and Death			
Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	MYOCA consequence of):	RDITIS	•		_	Onset and Death			
Examiner Sequentially list conditions, if any leading to immediate	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events c.									
A service Cutes I be death does										
D ciar e	resulting in death) Last Due to (or as a consequence of):									
certificate by sending physical property of the contribution of th	On If we automo									
The fedures that the death certific the death certific the death certific the death certific that the death certific the death certific that the death	23c. If yes, outcome o 1 Live Birth 2 4 Pregnant at 9 Unknown	Fetal death 3	☐ Ectopic pregnanc ☐ Other (specify)	y		23d. Date of delivery Month Day Year				
The law requires that the death after has been signed by the after him and the after has been signed by the after him and the after him and the after him and the after him and the after him and the after him and the aft	-	it not resulting in the	underlying cause giv	en in Part I.	23e. Did tot		to the cause of death? Probably 4 □ Unknown			
Vital Records, vivision. The law requires is certificate has been significate has been significate has been significate has been significate has been significant has been signif			00 PI	Death (Charle	24a. Was all autops perform	sy prior to	autopsy findings available o completion of cause of ? es 2 \square No			
25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nt 2 ER/Outpati	Othe	r: 4 Nursing Ho		ence 6 Other (Sp	ecify)			
27. Manner of Death 27. Matural 5 Pending 22. Accident Investigat	28a. Date of injury (Month, Day,		work	at ? Yes 2 \(\sum \) No	28d. Describe ho	w injury occurred				
27. Manner of Death 22. Manner of Death 23. affect death 24. a price of the function o	t be	ry - At home, farm, s (Specify)	treet, factory, office	28f. Location (St. City or Town	reet and Number or F , State)	Bural Route Number,				
29a. Certifier 1 Certifying P	hysician: To the best of numiner: On the basis of exurese Practioner: To the b	amination and/or inve	stigation, in my opinio	n, death occurred at	the time, date an	d place, and due to the	e cause(s) and manner stated.			
29b. Signature and Atle of certifier	e 1	Mb	29c. License	1056		9d. Date signed (Mor	nth, Day, Year)			
30. Name and address of person where the ATHER LOREA	o completed cause of de	ath (Item 23a) (Type,		HILIP D	R OLA	LEY MD	20832			
State Registrar 31. Date filed (Month, Day, Year) JAN 2 6 20	31. Registrar	's Signature	wes							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEN#29dpcmD, 1/28/10, BW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 01/25/2010 Day Ye ar 3:00 P M MARGARET RYAN 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's 9010 Briarcroft Lane, #111 Laurel Birthplace (State or Foreign Country) AL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Days Hours 1 □ M 2 🕅 F 08/20/1914 95 213-32-2978 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Prince George's Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20708 9010 Briarcroft Lane, #111 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2¥ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2√☐No Specify: Specify. 3√2 Widowed 4 □ Divorced Black 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custodial Worker Hotel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alice Carlie Robert Lewis May 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8447 Beacon Avenue South, Seattle, WA 98118 Clarence Daniel Ryan - son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) of Heaven 2/1/10 Silver Spring, MD Gate 22. Name and Address of Facility 21. Signature of Funeral Service Lice Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. on not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiamyopathe y ears Due to (or as a consequence of) Sequentially list conditions, if any leading to in models cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 Dlnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Alzheouers 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation

Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar been signed by the should be detached

Division of Vital Records, P.O. Box 68760,

Exami Physician/Medical Completed by page 2 s r this certificate haral director, page Be Certification: To After thi within 24 hours after death

To the Funeral Director;
completely filled in by the

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show

"natural",

Health and Mental Hygiene. tem 27 Is marked other than "natur other traumatic event, Inc. Prodiced

permit. Pages 1 and 2 at Department of Health an Important: If item 27 Is any injury or other trauonce.

Physician

/Medical

Director

by Funeral

Completed

Be

2

MD

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

25. Was case referred to medical examiner? 1 Yes 2 No

28a. Date of Injury (Month, Day, Year) Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my online. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

6 ☐ Could not be

determined

29c. License number D 37142 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Geoffrey Coleman, M.D. Powder Mill Calverton

State Registrar

Medical

31. Date filed (Month, Day, Year) 28 2010 32. Registrar's Signature

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 26, 2010 10:50 A M Lillian RUBINSTEIN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Chevy Chase Montgomery 8100 Connecticut Ave., #218 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)

New York **Funeral** 8. Date of Birth 1 M 2 K F Aud Year 99, Year 913 Director 96 198-32-9186 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Chevy Chase Maryland 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20815 United States 8100 Connecticut Ave., #218 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 V No Specify: 3 X Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jean Starcelski Joseph Tamarkin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3212 Coquel in Terrace, Chevy Chase, MD 20815 permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trans Joyce Sperling, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Beth El Cemetery Date 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 N Removal from State 4 □ Donation 5 □ Other (Specify) 02/01/10 Ft. Lauderdale, FL Signature of Surieral Service Licensee T3PCHTMSKYSSHEBWew Funeral Home MOLOD8 254 Carroll St., NW. Washington, DC Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Metastatic Cancer of Unknown Primary disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 N No
9 Unknown Pregnant at time of death Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autonsv performed? Yes 2 X N he Hospital or Attending Physician: The I in 24 hours after death.
he Funeral Director: After this certificate hipleted filled in by the funeral director, page death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Tes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural 5 Pending 1 Yes Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined To the Hospital o Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier certifying Nurse Pactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)
January 27, 2010 DO 30247 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Alan Morrison, M.D., 5410 Connecticut Ave., NW, #103, Washington, DC 20015

State Registrar 31. Date filed (Month, Day, Year) JAN 28 2010

Box 68760

P.O.

Records,

Division of Vital

Registrar's Signatu

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State of Maryland / Department of Health and Mental Hygiene

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		1- For State Certificate of Death Reg No.													
Physiciai Medical Examin	n/. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year												3. Time of Death 0458 hrs		
		4a. Facility Name (if no Sinai Hospital	t institution,	give street and no	umber)		41	o. City, Town, or Baltimore	Location	of Death	4c. County of De Baltimo				- City
Funeral Director		5. Social Security Numb		. Sex	7. Age (In yrs.	last birt	hday)	If Under 1 Year			8. Date of E			9. Birt	hplace (State or
Director	-	218-27-746 Usual Residence of De-		1 M 2 F	^M 2□F 20						01/19	9/199	0	Cou	untry) MD
w any	Ī		. County		10c. City	y, Town	or Locatio	n							10d. Inside City Limits 1 Yes 2 No
iaryland 8a-f show any at once.	횽	MD M 10e. Street and Numbe	<u>Iontgo</u>	mery	No	rth	Poto	MaC 10f. Zip Code			T	10a. Citiz	zen of Wh	at Cour	
ith the Maryland 23a or 28a-f sho notified at once.	Director	9619 Marat		'erra c e				20878				US			
ath with tems 23	Funeral	11. Marital Status 1 Y Never Married	1. Marital Status 12. Was Decedent Ever in Armed Forces?					Decedent of His s, specify Cubar				0-		ice - American Indian, Black, hite, etc.	
	by Fu			ced If Yes, Give Yes	² No 2009-	·10	1 🔲 🕻	res 2 X No	specify	r:			S <i>pecify:</i>	Bla	ack
hours."natur	ed F	15. Decedent's Educa Elementary/Seconda						s Usual Occupa st of working life				16b. K	ind of Bus	iness/Ir	ndustry
036 ithin 72 ne. r than	Completed	12					s. Ma	rine				Ar	med	Ser	<i>r</i> ices
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (Firs	t, Middle, L	^{ast)} Ukn	·						First, Middle, Maiden Sur		Surname)	urname)	
ID 21215-003 s should be filed within and Mental Hygiene, is marked other it matic event, the Med	일 Re												Zip Code)		
e, MD 2 l and 2 shou Health and N item 27 is n r traumatic		Lennice Hu		- mother				iarathon			rth Po				
nore, ages la nor of He it: If ite other t		1 X Burial 2 0	Cremation		rom State	cremato	ory or othe	r place)						- City or Town, State	
Baltimore, permit. Pages la Department of He Important: If ite injury or other ti	ł		Donation 5 Other Specify: All Souls Cemetery 2/3/10 Germantown, MD 22. Name and Address of Facility Snowden Funeral Home												
	4	23a. Part I. Enter the dis		omplications that of	aused the death			N. Was							20850 Approximate Interval
Physician /Medical		failure. List only or Immediate Cause (Fina	ne cause or	each line. a. Stab Wour		'					, a. a. a. a. a. a. a. a. a. a. a. a. a.	7001, 0110	,		Between Onset and Death
Examiner		or condition resulting in			consequence										
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause														
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8760, rtificate be ing physic as the burn	Me 2		decedent pregnant in the 1 Live birth a Fetal death 3 Fetanic pregnancy Month								-	av Year			
Box 68 e death certi	Physicial	past 12 months? 1 Yes 2 No 9	Unkno	4 Pregr	ant at time of de	eath 5		(Specify)		- program	,				-y 1001
P.O. Box 68 s that the death certify gred by the attending e detached for use as		Part II. Other significar		9 Ouku		resulting	in the un	derlying cause o	given in P	art I.	23e. Did	tobacco u	ise contrib	ute to ti	ne cause of death?
S, P.O. uires that the signed by doe detack	9														ably 4 Unknown
cords,	Completed by										24a. Was auto		pr		opsy findings available ompletion of cause of
ian: The certificate ector, page												✓ Yes	2 No		
Vital F nysician: this certifi	9 0	examiner?	_	Hospital: 1	Inpatient 2	ER/Ou	tpatient	\rightarrow	Other4	Nursing I		Residen	ice 6	Other:	
		27. Manner of Death 1 Natural 5	Pendin	28a. Date (Month Jan 23,	of Injury Day Year) 2010	28b. T 0410	ime of Inju		ry at Worl Yes 2 ✔	. le.	d. Describe ubject wa			d	
Division pital or Attent ours after death eral Director: filled in by the	Certification:	2 Accident 3 Suicide 6	Investig Could r	not be 28e. Plac	e of Injury - At h	nome, fai	m, street,	factory, office b	uilding, e	tc. 28	f. Location or Town,		d Number	or Rur	al Route Number, City
Div Hospital or 24 hours aff Funeral Di tely filled in		4 Homicide 29a. Certifier 1 Cert	determi	sician: To the bes	Townhous		th occurre	d at the time da	ate and n		08 McClea	in Boule			
To the Hos within 24 h	ופּס	(Check only		ner:On the basis and manner s	of examination a										
3	Σ	29b. Signature and title	of certifier	(1) m	\			29c. Licens O.C.I					ate signed ary 23,		h, Day, Year)
		30. Name nd address of	of person wi	no completed caus	se of death (Iten	n 23a)] 3.0.1				Junio	, 20,		
		Melissa Brasse		Assistant Me				nn Street, B	altimor	e, MD 21	201				
Stat Registra	te ar	31. Date filed (Month, D	2 8 20	10 Sene	egistrar's Signa	ure	arks								

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04322 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Betty ROSENGARTEN Physician/ January 28, 2010 10:50 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hebrew Home of Greater Washington Rockville Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Ye March 31 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Days Hours Months Director 120-03-3370 1916 Pennsylvania 93 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No <u>Maryland Montgomery</u> Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 United States 133 Monument Street death Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖾 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", Specify: 3 Widowed 4 Divorced Completed Year or Dates. event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Upholstery International Elementary/Seconday (0-12) College (1-4 or 5+) Executive Union Page 1 and 2 should be filed wit ment of Health and Mental Hygie ant: If item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rachel Zaroff Simon Seder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 133 Monument Street, Rockville, MD 20850 Susan Hoffmann, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place. Judean Memorial Gardens 01/31/10 Olney, MD Torchinsky Hebrew Funeral Home <u> 254 Carroll St</u> NW. Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Pulmonary Hypertension Onset and Death .Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Chronic Obstructive Pulmonary Disease Sequentially flet ounditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innertal director, page 2 should be detached for use as the burial-transit Congestive Heart Failure that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Coronary Artery Disease Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Day Pregnant at time of death Other (specify) Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign. Dyslipidemia 1 Yes 2 No 3 Probably 4 Yunknown Peripheral Vascular Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 \(\sum \text{ Yes} \quad 2 \sum \text{ No} \) 1 X Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6/1/ 2 29 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 20852

Rockville, MD

Damien Doyle, M.D., 6121 Montrose Road,

31. Date filed (Month, Day, Year) **FEB 0 1 2010**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Rose Lillian 2010 11 PM January Medical 4c. County of Death Montgomery 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 01ney Montgomery General Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Canada 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 💢 F Days Hours Min. 051/26 14.909 100 216-76-2975 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 X Yes 2 □ No Silver Spring MD Montgomery 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 20906 United States 15101 Glade Drive #3A 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home nd Mental Hygien marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Julius Sand Stella Funger permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7007 East Avenue Chevy Chase MD 20815 Joseph Rose - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) King David Memorial Gardens 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 Donation 5 Dother (Specify) 01/29/2010 Falls Church, VA 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels Inc
II/O Rockville Pike Rockville MD 20852 21. Signature of Funeral Service M01163 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events the attending physician and hed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death 2 No been signed by the sahould be detached 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖄 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 autonsv performed? Yes 2 No 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 1 No 1 🔲 Yes 잍 1 Monpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) iniury work?
1 Yes 2 No 5 Pending Matural Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, To the Hospital or Attaction of the Tother of Tothe Funeral Direct determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, it into opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) eum 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18404 Oxfordshire Terrace Olney MD 20832 Aruna Kumari Paspula 31. Date filed (Month, Day, Year)

JAN 29

State

Registrar

Registrar's Signat

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- StateAmended #4a per MD FCHD RG 1/2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 19, 2016 Rhoderick 5:50 P Vivian J. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 550 Cotswold Court 560 Cotswold Court Frederick Frederick . Social Security Number 6 Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Month, Day, Months Hours Min. Director Mary Land 82 212-24-7362 May Usual Residence of Decedent 28a-f show 10a State 10b County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Frederick Frederick 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country's United States items 23a Funeral 21703 560 Cotswold Court 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i Black, White, etc. ρ 1 Never Married 2 Married 1 Yes : Baltimore, Maryland 21215-0036 2 XNo 1 Yes 2 XNo Specify: White Completed 3 Widowed 4 Divorced Specify Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Assembler Optical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul M. Boone Laura Anders other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 560 Cotswold Court, Frederick, MD 21703 Doris Burdette / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5 cemetery, crematory or other place) injury Frederick, Maryland Resthaven Memorial 1/23/2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician disease or condition resulting in death) di ar Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown After this certificate has been Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 1 \(\subseteq \text{Yes} \) Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident Investigation 1 🔲 Yes 2 🗌 No 24 hours after death Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of 29d. Date signed (Month, Day, Year) 20 3/05 my 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 10200 Coppermine Rd., Gene Ashe, Woodsboro, MD 21798 31. Date filed (Month, Day, Year) JAN 00 0 32. Registra 's Signature State

DHMH 17 Rev 7/2009

Registrar

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State of Maryland / Department of Health and Mental Hygiene 🤈 04325 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Mary Emma Racine February 2010 03:45 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ceci1 Calvert Manor Healthcare Center Rising Sun If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. 18, 1910 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖫 F Maryland 221-01-3336 99 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show d other than "natural", or items 23a or 28a-f sho event, it of the lice Examiner must be notified at Director 1 ☐ Yes 2 ☑ Nio Maryland Ceci1 Rising Sun death with the 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1881 Telegraph Road 21911 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify 2 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, It a Maonce. Elementary/Secondary (0-12) College (1-4or 5+) Stenographer Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last, Be Eugene Racine Eleanor Conlyn 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene Steward / Niece 18 Colonial Circle, North East, Maryland 21901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Fel ebruary 2010 Burial 2 Cremation 3 Removal from State Friends Cemetery Calvert, Maryland 4 □ Donation 5 □ Other (Specify) 21. Sign and of Fundal Savin Lie 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VLMONAR **Physician** /Medical ue to (or as a consequence of): **Examiner** 1 RATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed STROKE and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Ø No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) been signed by the should be detached 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an has autopsy 2 No 1 Yes To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other:

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 2 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RISING SUN, MD 781 MAIN STREE E. 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

10-00938 Justo E. Rosario, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 04326

		1- For State Registrar		Cei	rtificate of	Death				F	Reg. No.			
Physici			lle,Last)				-		2	. Date of De		Voor		3. Time of Death
edical Exami	iner	Justo E. Rosa	ario, Jr.							Month February	Day 1, 201	Year 10		2258 hrs
		4a. Facility Name (if not institution	on, give street and r	iumber)		4b. City, To	wn, or L	ocation of				. County of I	Death	
		S/B Riggs Road and I	Forest Dale Dr	ve	1	Beltsvi	le				F	Prince Ge	orge'	S
Francis 1		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast hirthday)	If Under	1 Year	If Under	24Hrs	B Date of B	irth (MM/	/DD/YYYY	9. Birth	place (State or
Funeral Director				, , ,	,,	Months	Days	Hours	Min.			l F	oreign	Dominican
Director		578-19-2588	1 X M 2 F	30	Yrs					Septeml	ber Z	1,19/9	Cou	ntry) Republic
		Usual Residence of Decedent												
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pu w	_	Maryland Princ	ce George	's Hya	ttsvill	.e								1 X Yes 2 No
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th the Maryland 23a or 28a-f sho notified at once.	Director	7313 23rd Ave	27110				2078	33			Dom	inica	n R	epublic
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5-0036 iled within 7: Hygiene. I other than	Completed	12			Compe	iter i	ecin	пста	111					
5-00 led wit Hygien other the Mo	ပိ	17. Father's Name (First, Middle	, Last)				18			irst, Middle,		Surname)		
21215-0036 Mental Hygiene. marked other than "natural" event, the Medical Examine.	Be	Justo E. Rosa	ario, Sr.							Aza-R	-			
21 ould b Mer i mar	7	19a. Informant's Name/Relations	ship (Type, Print)									ity or Town,		
MD id 2 sho ulth and m 27 is aumati		Angela Rosar:	io / Sist	er	2305	Erski	ne S	Stree	t, H	lyatts	vill	e, MD	20	783
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ten fof Healand and Mental Hygiene. Int. If item 27 is marked other than "natural", or items 23a or 28a-f she rother traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition			Place of Dispos		of ceme	etery,		Date	20c.	Location - C	ity or T	own, State
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im Pag ment tant		4 Donation 5 Other S		Geo	orge Wash			- 1		, 2010	1		,	
Baltimore, I permit. Pages 1 and Department of Heal Important: If item injury or other tra		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Balt												ore Avenue
E.E.O.S. UI		Gasch's Funeral Home, P.A. Hyattsvil												
Physician		23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and
/Medical Examiner	ķ 99	Immediate Cause (Final disease	Maria ala la	juries									- 1	Death
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	ner	if any, leading to immediate cause. Enter Underlying Cause	•	a consequence o	of):									
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8760, ifficate be	≥	IF FEMALE: 23b. Was decedent pregnant in the		, outcome of preg	nancy 2 Fe	tal doath	3	Ectopic	nreanana	-v	230	d. Date of de Month	Da	ay Year
Sox 687 leath certific e attending I for use as the		past 12 months?		nant at time of de	noth -	her (Specif			program	-,	-	Teloritor		.,
Box e death c the atten ed for us	/sic	1 Yes 2 No 9 Un	known	nown	3 [] ()(ner (Specii								
the d	Physicia	Part II. Other significant condit	tions contributing	to death but not r	esulting in the u	inderlying o	ause giv	en in Par	t I.	23e. Did	tobacco	use contribu	ite to th	ne cause of death?
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Records, The law require	Completed									auto	psy	pric	or to co	mpletion of cause of
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ician s cert rectc	Be	examiner?	Hospital:	Inpatient 2	ER/Outpatient						Reside	ence 6	Other	Scene
Division of Vital as of or tending Physician: rs after death. The Director: After this certified in by the funeral director	To	1 Yes 2 No 27. Manner of Death	28a. Dat	e of Injury	28b. Time of I			at Work?				ury occurred		
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sio tten death ctor:	ati		stigation Feb 1,		2246 hrs					Of Landing	/011	and Marsachana	or Dive	-I Davida Niverbox City
Vision A	tific		ild not be	ice of Injury - At h	ome, farm, stre	et, factory, o	mice bu	ilaing, etc.	. 2	or Town,	State)	ing Number	or Rur	al Route Number, City
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and inpletely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	Certification:	4 Homicide		noadway										Drive, Beltsville, M
Hos 24 h Fun		29a. Certifier (Check only 1 Certifying P	hysician: To the b	est of my knowled	lge, death occu	red at the t	me, date	e and plac	ce, and d	ue to the cau	use(s) ar	nd manner as	s state	d.
To the Hos within 24 h To the Fu	Medical	one) 2 Medical Exa	aminer: On the basis		and/or investiga	tion, in my o	pinion,	death occ	urred at t	the time, date	e and pla	ace, and due	to the	cause(s)
F 3 F 3	Me	29b. Signature and title of certific				29c.	icense	number	004	er.	29d.	Date signed	(Mon	th, Day, Year)
		1 0 11	V. 1.	10	1		O.C.M	I.E.	OCM	16	Feb	ruary 2, 2	2010	
1		30. Name and address of persor	who completed on	use of death (Item	n 23a							-		
16		Theodore M. King, Jr.		tant Medical E		111 Per	n Stre	et, Balt	imore,	MD 2120)1			
	tate		1	Registrar' Signat	4									

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Maryland		artment of H <i>rtificate of L</i>			jiene _{eg. No.} 2 (110	04327		
_		Decedent's Name (First, Middle, Last)					2. Date of Deal	-	/10	3. Time of Death		
Physicia	an	Samuel Edward Rak	estraw				Month Februar	y 1, 20	Year 10	1:05 A ^M		
/Medic		4a. Facility Name (If not institution, give si			4b. City. Town, or	Location of Death		4c. County				
Examin	er	Casey House	, con and manned,		, ,	cville		1	tgome	rv		
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day		9. Birthpi	lace (State or Foreign		
Director		249-44-3286 ¹	M 2□F 80	Yrs.	Months Days	Hours Min.	April 1	2, 1929	Coun Pau1	ine, SC		
		Usual Residence of Decedent										
rylan how	_	10a. State 10b. County	10c. City,	Town or Lo	ocation				110	0d. Inside City Limits 1 ☑ Yes 2 ☐ No		
r 28a-f show	cto	Maryland Montgome	ry Poto	mac								
or 28	Director	10e. Street and Number			10f. Zip Code	2005/	10g. Citizen of What			try?		
filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or Items 23a or 28a-f show ent, the Modical Examiner must be notified at	ra	11517 Deborah Dri				20854		US				
ltems	Funeral	11. Wartar Glatas	Was Decedent Ever in U.S Armed Forces?	. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)		e - Americ k, White, e			
iurs afte ai", or I Examir	by F	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🎛 No	Specify:		Specify	. Whi	te		
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ild be fenta rked ric ev	TO E	John Rakestraw				Sally F	inlay					
shou and N s ma	_	19a. Informant's Name/Relationship (Typ	e. Print)	19b. Maili	ng Address (Street a	and Number or Ru	ral Route Numbe	r, City or Town,	State, Zip	Code)		
and 2 salth a 127 i		Al Hussian Khan /	Friend	1151	l7 Deboral	n Drive,	Potomac	, MD 20	854			
of He of He ritem		20a. Method of Disposition	20b. Pla	ace of Dispo metery, cre	osition (Name of matory or other place	e)	Date	20c. Location -	City or To	wn, State		
Page nent nnt: It		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		oln Cemeter		2010	Brentwo	od, 1	Maryland		
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exagnee.		21. Signature of Funeral Service License	е	2	2. Name and Addres	ss of Facility		4739 B	altim	ore Avenue		
9 9 E E 9		Claudette Das	ch Lannine	G.	asch's Fu	neral Hor	ne, P.A.	Hyatts	ville	, MD 20781		
		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death	Do not en	ter the mode of dyin	g, such as car d iac	or respiratory are	rest,		Approximate Interval Between Onset and Death		
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/Medical Examiner		resulting in death)										
Examiner	-	Sequentially list conditions, b.	Cerebrovascu		ccident_							
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque									
law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	xan	that initiated events c. resulting in death) Last	Due to (or as a conseque	ence of):								
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leath a atte	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		☐ Ectopic pregnanc: ☐ Other (specify)	у		Mo	onth	Day Year		
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aw requir as been si 2 should b	Completed						24a. Was a		Were auto	psy findings available		
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sician: The la certificate ha rector, page 2	Be C	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes		1 🗆 163	2 110		
ysici is cel direc		examiner? 1 ☐ Yes 2 🖾 No	ospital:	ER/Outpatie	ent 3 DOA Othe	er: 4 🗆 Nursing H	lome 5 Resid	ience 6 🖾 Oth	ner (Specil	y) Hospice		
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r Atte	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify		reet, factory, office		28f. Location (S City or Tow		ber or Rura	al Route Number,		
ital o urs aff ral Di												
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical	(Check only 2 Medical Examin	er: On the basis of examinat	vledge, dea ion and/or i	th occurred at the tir nvestigation, in my o	me, date and place pinion, death occu	e, an d d ue to the arred at the time,	cause(s) and m date and place,	anner as s and due to	stated. the cause(s)		
thin 2 the l	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens	e number		29d. Date signe	ed (Month	Dav. Year)		
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		20 Name and a discount	malated earlier of Pro-Mr /II	22a\ /T:					_,			
25		30. Name and address of person who con Bindu C. Joseph,	·-			ockville,	MD 2085	55				

State Registrar

31. Date filed (Month, Day, Year) FEB 0 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20a-c Per FH G901 3/09/2010 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year Velma D. Reeves anua Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yes 1 □ M 2 🖾 F Months Days Hours Min North Carolina Director Yrs 240-70-9618 64 1945 Usual Residence of Decedent or 28a-f show a notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
Lant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be by Funeral 701 N. Arlington Ave. # 63 21217 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: African If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 ☐ Widowed 4 🛂 Divorced Completed American permit. Page 1 and 2 should be filed within 72 hour Department of Health and Aental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Nurse Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Kornegay Pearlie Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Reeves/ Daughter 227 Denfield Drive Alexandria, VA 22309 20b. Place of Disposition (Name of Leems place) 20a. Method of Disposition 20c. Location - City or Town, State Clinton, MD 2/24/2010 Mt. Olivet Washington, DC 2010 Ji nature of Funer J Service Livens 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE Washington, DC 20019 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year 1 Yes 2 I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation within 24 hours after deat To the Funeral Director: filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital c 24 hours at Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month. Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Box 68760, P.O. Records, Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04329 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear Physician 12:21 A.M Smulsky January 25. 2010 Angeline Marie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7017 Needwood Road Derwood Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Davs Hours 1 □ M 2 🖾 F 68 Oct. 12, 1941 Pennsylvania Director 168-34-5024 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County 28a-f show ral", or items 23a or 28a-f shore Examiner must be notified at 1 ☐ Yes 2 No Director Maryland | Montgomery Derwood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20855 United States Funeral 7017 Needwood Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or item any injury or other traumatic event. The Mental Page. Black, White, etc. 1 ☐ Yes 21K If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐Yes 2 🛣 No Specify Specify: 2 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Office Manager Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ Ottaviani Florence Roman Anthony 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Edward P. Smulsky/Husband 7017 Needwood Road, Derwood, Maryland 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/28/2010 Alexandria, Virginia Metropolitan Crem. 22. Name and Address of Facility DeVol Funeral Home Signature of Funeral Service Licenses 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 10 Years Scleroderma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Year Day 5 ☐ Other (specify) 9 Unknown Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Anemia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an Anonexia autopsy 1 ☐Yes 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 January 25, 2010 D 53528 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Daphna Henkin, M.D., 31. Date filed (Month, Day, Year)

JAN 26 2010

2. Registrar's Signature

18121 Georgia Avenue, # 103, Olney, Maryland 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20°F6 9:35 p.m. Hattie Mae Shields Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Arcola Heath & Rehabilitation Center Silver Spring Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. II 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖵 F Mississippi Director 1921 438–36–8715 88 Usual Residence of Decedent 10a State 10b. County Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director D.C. Washington N/A 28a-f 1 Yes 2 □ No 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 20015 5810 Oregon Ave., USA items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ŏ ģ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Black If Yes, Give Specify "natural", 3 XWidowed 4 Divorced Completed Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary/ Admin. Aide Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Walker Susan McCormack Walker . Page 1 and 2 should ment of Health and M lant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) - Daughter Dorothy West 5810 Oregon Ave., NW, Washington, D.C. 20015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) o Department of Important: If any injury or Chesapeake Crematory Beltsville, Maryland 1/26/2010 21. Signature of Funeral Service Licensee 7400 Georgia Ave., 22. Name and Address of Facility McGuire Funeral Service, Inc.Washington, D.C. 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Gastrointestinal Bleeding Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Atrial Fibrillation Due to for 88 a paresonner of cause. Enter Underlying Cause (Disease or iinjury Exam certificate be executed Coronary Artery Disease sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Renal Insufficiency Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Other (specify) Ectopic pregnancy ō in the past 12 months?

1 Yes 2 No 4 Pregnant : 9 Unknown Month Day Pregnant at time of death the detached g Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Dementia, History of Urosepsis page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No 2 X No Yes 25. Was case referred to medical or Attending Physician: Be 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 🗌 Yes 2 🔯 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 24 hours after death.
Funeral Director: After teled filled in by the funeral Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 7 29b. Signature ar 29d. Date signed (Month, Day, Year) 00 57570 January 22, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Ahmed Heshmat, MD
31. Date filed (Month, Day, Year)

JAN 2 6 2010

arke

2. Registrar's Sign

10301 Georgia Avenue, Suite #201 Silver Spring, Maryland 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04331 State
Registrar AMEND#20boerrFH, 1/29/10, BMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 2:30 A.M Salamanca January Mildred Norton Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery <u>Suburban Hospital</u> Bethesda Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, 1 □ M 2 🛣 F Months Days Hours Min. 920 Washington, **Director** 559-14-7531 89 2130 am Usual Residence of Decedent shov 10b. County 10a. State 10c, City, Town or Location 10d. Inside City Limits death with the Maryland the Medical Examiner must be notified at Direct 28a-f 1 Yes 2 X No Maryland Montgomery Potomac 20 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 10843 Deborah Drive 20854 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 K Married by Yes Yes, Give 2 X No Maryland 21215-0036 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 4 Stage and Screen Actress event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ other traumatic Albert Norton Dorothy Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau 10843 Deborah Drive, Potomac, Maryland 20854 Jack Richard Salamanca/Spouse Baltimore, 28^{Date} 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Oak Cemetery 1/26/2010Gaithersburg, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility DeVol Funeral Home VUV. 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ Acute Mesenteric Ischemia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): physician and s the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Salaman Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 K No Month Year Pregnant at time of death ed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an the Hospital or Attending Physician: The law this certificate has page 2 autopsy performed' death? 1 Yes 2 No Yes 2 X No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 🗌 Yes 2 🔀 No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injury 1 X Natural (Month, Day, Year) 5 Pendina death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation within 24 hours after death

To the Funeral Director: A completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0 300 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sujoy Tagore, M.D., 8600 Old Georgetown Road, Bethesda, Maryland 20814 31. Date filed (Month, Day, Year)
JAN 26 Registrar's Signat State 2010 Registrar

DHMH 17 Rev 7/2009

82

04,332 State of Maryland / Department of Health and Mental Hygiene 2 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2:35 pm Robert L. Staten Tanuaru 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Asbury Methodist Village Gaithersburg Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Kentucky 8. Date of Birth **Funeral** Year 1926 1 **X** M 2 \square F Months July 01 **Director** 407-22-2326 83 Usual Residence of Decedent fshow 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27: is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits Maryland 1 🗌 Yes 2 🗶 No Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 415 Russell Avenue, 20877 12. Was Decedent Ever in U.S. Armed Forces?
1

Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced WW I I White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Personnel Officer CIA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Foster Staten Blanche Mae Appleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma Staten - Spouse 415 Russell Avenue, #106, Gaithersburg, MD 20877 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Crematory 01/28/2010 | Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Simple Tribute FH & Cremation Ctr M00709 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death
Months Immediate Cause (Final Physician/ Congestive Heart Failure Medical resulting in death) **Examiner** Coronary Artery Disease Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for sels our explication of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death Dav Year Yes 2 No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 🗶 No Certificate: To Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier J. Robert Dirach knuary 26,2010 9+1 D04115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Birschbash, M.D., 201 Russell Avenue, Gaithersburg, Maryland 20877 31. Date filed (Month, Day, Year) State Registrar's Sign 28 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 Never Married 2 Married

3 Widowed 4 Divorced

Ben Skolnick

1 ∐Yes 2 XNo

If Yes, Give Year or Dates

Yrs

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify: 16a. Decedent's Usual Occupation

Certificate of Death

Chevy Chase

20815

(Give kind of work done during most of working life. DO NOT use retired)

Months Days

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Hours

14. Race - American Indian, Black, White, etc. Specify: White

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 X Yes 2 □ No

8:15 A^M

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+17. Father's Name (First, Middle, Last)

Camp Director 18. Mother's Name (First, Middle, Maiden Surname)

Libby Lisack 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19a. Informant's Name/Relationship (Type. Print) Lynn S. Sachs / daughter

2900 45th Street NW Washington, DC 20015

Date

20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify)

20b. Place of Disposition (Name of Judean Memorial Grdn. 01/29/2010

Olney, MD

Reg. No.

2010

4c. County of Death

Montgomery

10g. Citizen of What Country?

United States

16b. Kind of Business/Industry

20c. Location - City or Town, State

2. Date of Death

January 27,

09/ 18/1926

Month

21. Signature of Funeral Service Licensee Edward Sage1 M00910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike rockville, MD 20852 Approximate Interval Between Onset and Death

disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Congestive Hea	art Failure
Due to (or as a consequence of	
Mitral Valve I	Regurgitation
D	

Due to (or as a consequence of)

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 9 Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 9 Unknown

5 Other (specify)

Month Year Day

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

10 Years

5 Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Artrial Fibrillation

Mitral Vavle Stenosis

autopsy performed

1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown

1 ☐ Yes 2X No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐No

Pulmonary	Hypertensio
Was case referred to me	dical

1☐Yes 2X No 27. Manner of Death 5 Pending

investigation

Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 01/27/2010

leena f. Shapur,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deena J. Shapiro M.D. 10810 Connecticut Ave. Kensington, MD 20895

State Registrar 31. Date filed (Month, Day, Year) JAN 29 2010



DHMH 17 Rev 1/2001

Physician /Medical **Examiner** Box 68760. P.O.

Baltimore, Maryland 21215-0036

Completed

Be

Examiner

Physician/Medical

þ

Medical

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, ours after death. death.

To the Hospital within 24 hours a To the Funeral C

20

Completed Be Certification: To

1 X Natural 2 Accident

3 ☐ Suicide 4 ☐ Homicide

29a. Certifier

6 ☐ Could not be

determined

🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D35336

10-00880 James Swinfo

		Please Type or Print in Black Indelible Ink. Ensure All Copies Are I	_egible.	01.23
rd		State of Maryland / Department of Health and Mental Hygiene	2010	0400
	1- For State	Certificate of Death		

		- For State Registrar		C	Certificat	e of	Death			Reg. No.					
Physicia		Decedent's Name (First, Midd	e,Last)							Month Day Year			3. Time of Death		
Medical Exami		James R.	Swinford					1, 2010		0711 hrs					
		4a Facility Name (if not institution Washington County H	. •	ımber)		4	b. City, Town, or Lo Hagerstown	ocation of I	Death		4c. County of Washing				
Funeral	7	5. Social Security Number	6. Sex	7. Age (In y	7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/D										
Director	į	403-17-5775	1 X M 2 F		34	Yrs.	Months Days	Hours	Min. (Oct.	18, 1975	Foreigr Cou	^{ntry)} Tennessee		
8		Usual Residence of Decedent 10a State 10b County		Tage (City, Town or		-						10d. Inside City Limits		
ne Maryjand or 28a-f show any fied at once.	٦	,	ington	100.	•		rstown						1 X Yes 2 No		
Marylar r 28a-f e	Director	10e. Street and Number					10f. Zip Code			1	0g. Citizen of Wh	at Count	ry?		
th the		17920 Hickory					21740		0.40		Jnited S		S an Indian, Black,		
th wi	Funeral	11. Marital Status 1 Never Married 2 X M		cedent Ever i orces?	n U.S. 1		Decedent of Hispa es, specify Cuban, I				- 14. Race White		an indian, black,		
fter dear I", or it							Yes 2 No	specify:			Specify:	Wh	ite		
ours a	15. Decedent's Education (Specify only highest grade completed) 16a.						's Usual Occupatio				16b. Kind of Bu	siness/In	dustry		
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036 ithin ane.	Completed		Co	mputer Re				Tech		gy					
5-0 led w Hygic othe	17. Father's Name (First, Middle, Last)							18.Mother's Name (First, Middle, Maiden Surname)							
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Dean C. Purvis									ita Ta			7.0.11		
D 21 hould and Me	19b. No. 1 19c. Informant's Name/Relationship (Type, Print)							ailing Address (Street and Number or Rural Route Number, City or Town,							
MD id 2 sho lith and m 27 is aumati		Jacqueline Swi	nford / W:				Hickory			gersto	wn, MD 2	2174	O State		
re, slan fHea If ite		20a. Method of Disposition 1 Burial 2 Cremation	a 3 Removal fi		ob. Place of t crematory		tion (Name of ceme er place)	etery,	Da	ale	200. Eucation -	City Of 1	TOWIT, State		
Page:	ı	4 Donation 5 Other S			Stauf	fer	Cremato	ry	2/3/2	2010	Freder	ick,	Maryland		
altimore, rmit. Pages l at popartment of He poparant: If ite	ı	21. Signature of Funeral Service		,			ame and Address o				fer Fun				
E E & B	- 1	1 our treel	Stauff	01		1	621 Oposs	sumto	wn Pi	ike, E	rederic	ς , Μ			
Physician	T	23a. Part I. Enter the disease, or failure. List only one cause	complications that o	caused the de	eath. Do not e	nter th	e mode of dying, s	uch as car	diac or res	spiratory arr	est, shock, or hea	art	Approximate Interval Between Onset and		
- /Medical Examiner	1	Immediate Cause (Final disease		yl and	d oxyc	odo	ne intoxi	catio	on				Death		
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Box 68 e death certif the attending	Physician	1 Yes 2 No 9 Un	known 9 Unkn	iown	3 [Otr	ier (Specify)								
cords, P.O. Box 68 aw requires that the death certif has been signed by the attending 2 should be detached for use as	F.	Part II. Other significant condi	tions contributing t	o death but r	not resulting i	the u	nderlying cause giv	ven in Part	l.	23e. Did to	obacco use contri	bute to t	he cause of death?		
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Sior Attend death. ctor:	ğ		stigation Fu	/31/10			am					er or Pur	al Route Number, City		
Division of Vital I Hospital or Attending Physician: A hours after death Funeral Director: After this certificity filled in by the funeral director.	Certification:	3 Suicide 6 X Cou	ld not be 28e. Place (Specify)	f	ound a	t r	et, factory, office bu esidence	iliding, etc.		or Town, S	State)17920 cown, MD	Hic	kory Lane		
ospital hours uneral ly fillec		4 Homicide 29a. Certifier A Continue F	hysician: To the be		wlodgo dogth	000115	red at the time, date	e and place				as state	d.		
the hin	Medical	(Check only one) 2 Medical Exa	aminer: On the basis	of examinati	on and/or inv	estigat	ion, in my opinion,	death occu	urred at the	e time, date	and place, and c	lue to the	e cause(s)		
To To	Be	29b. algnature and title of certific		1	300)	29c. License	number		_	29d. Date sign	ed (Mon	th, Day, Year)		
		Tieto !	the 1	eldo	1,0		O.C.N	1.E.			February 1	, 2010			
		30. Name and address of person	who completed cau	use of death (
Ô		Victor Weedn MD JD				11 P	enn Street, Ba	altimore,	MD 21	201					
		31. Date filed (Month, Day Year,		egistrar's Sig	gnature	150	aked								
Regis	trar	I L W	/*~		1"	1									

OCME

State of Maryland / Department of Health and Mental Hygiene 20 10 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Year SMITTH TANTIARY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK 5. Social Security Number 6. Sex 1 ፟ M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Director 218-24-9761 80 1929 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes X No Frederick <u>Mar</u>yland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21704 5514 Bartonsville Road filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 2 Yes 2 No 1951—
If Yes, Give
Year or Dates. 1953 Black, White, etc. 1 Never Married 2 Married Š Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 XWidowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Equipment Operator Be 18. Mother's Name (First, Middle, Maiden Surname)
Pearle Wolfe 17. Father's Name (First, Middle, Last) and Mental I permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injuy or other traumatic eve once. Marion Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4336 Basford Road, Frederock, MD 21703Ronald Smith / Son Baltimore, 20a. Method of Disposition
1 Disposition 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Resthaven Memorial 1/29/2010 Frederick, Maryland 4 Donation 5 Other (Specify) 21. Sign of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final Onset and Death Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ANCA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≥</u> obstructive disease of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? Yes 2 death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No 1 🗆 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 Haque onta 32. Registra 31. Date filed (Morth, Day, Year) s Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04336 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day DONALD STOLZ TANHARY :00P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. 7. Age (In yrs. last birthday, 8. Date of Birth Date of Birth (Month, Day, Year) 1946 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Director 63 199-36-2643 Feb. Pennsylvania Usual Residence of Decedent shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f 1 X Yes 2 No Maryland Frederick Frederick ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 215 Wyngate Drive 21701 United States ural", or items ? death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes, Give 2 No altimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No Specify: "natural", Specify: White Completed 3 Widowed 4 Divorced Year or Dates. Vietnam the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Assembler Electronic Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Donald P. Stolz, Sr. Louise Dickey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. 215 Wyngate Drive Barbara Stolz / Wife Maryland 21701 Frederick, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 \square Burial 2 \boxtimes Cremation 3 \square Removal from State 4 Donation 5 Other (Specify) Stauffer Crematory 26, 2010 Frederick, Maryland 21. Signature of 22. Name and Address of Facility Service Licenses Stauffer Funeral Homes, P.A 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Hospital or Attending Physician: The law requires that the death for in the past 12 months? Month Pregnant at time of death 2 No ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I emia exo 1 Yes 2 No director, 25. Was case referred to Be 26. Place of Death (Check only one) examiner? Other: ဂ္ 2 No ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 🍒 funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

2+1

State Registrar

DHMH 17 Rev 7/2009

Medical

29a. Certifier

only one)

29b, Signature and title of certif

31. Date filed (Month, Day, Year)

30. Name and address of person who compl

Ihomas

ed cause of death (Item 23a) (Type, Print)

KNEUR

32. Registrar's Signature

OhNSON

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mary A Swinburn 2010 Januar Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Yea
April 5,1 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🕱 F Months Hours Director 219-30-4096 74 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 28a-f 1 ☐ Yes 2 🛣 No Marvland Frederick Mt. Airv 5 10g. Citizen of What Country? 10f. Zip Code 23a Funeral 13132 Jesse Smith Road United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 0 ģ 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify "natural", Completed 3 X Widowed 4 □ Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Cartographer ILS.D. event, f Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o မ Department of Health and Ment Important: If item 27 is marker any injury or other traumatic Thomas J. Faulconer Agnes Cornelia Perryman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dale Swinburn/ Son 13132 Jesse Smith Road, Mt. Airy, Maryland 21771 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Μt Olivet Cemetery 1/25/2010 Frederick, Maryland permit. Signature of Funeral Service Line 22. Name and Address of Facility. Stauffer Funeral Homes P. A. 1621 Opossumtown Pike. Marvland21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Sepsis Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Days pheumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ P in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has t completed filled in by the funeral director, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ပ 1 PInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29c. License number 29b. Signature and title of certifier nuary 19, 2010

State Registrar

DHMH 17 Rev 7/2009

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barko

400 West

3 . Regi ar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 3:40 P 25, 2010 Evelyn Stout January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Loyalton of Hagerstown Washington Hagerstown
If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 6. Sex **Funeral** Hours Months Days 1 M 2 F 4,1913 Director 96 Virginia <u> 219-30-1932</u> Nov. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Nedical Examinations to notified at 1 Yes 2 No Director Hagerstown Maryland Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21740 United States 421 South Edgewood Drive Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates: Specify Specify 2 3 ₩ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home <u>Homemaker</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Chamblin ဥ <u>Corneluis Shafer</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) South Edgewood Drive, Hagerstown, Maryland21740 Cheryl Eckard / Granddaughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1/28/2010 Park permit. Pages Department of Important: If it any Injury or or 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) Elkridge, Maryland. 4 Donation <u>Meadowridge Memorial</u> 22. Name and Address of Facility
Stauffer Funeral Homes P. A. 21. Signature of uneral Service Dicens 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Pari 1. Enter the disease, or complicate his that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final --Physician 0 WEEK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner STABLE EMENTIN MONTHS END Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed CONGESTIVE HISTORY OF attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2: autopsy performed 1 □Yes 1 ☐ Yes 2 ☑ No 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a Funeral I 🖒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MO

State Registrar

10

MI

190 32. Registrar's Signature 1 MEOUND W

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

QADIA

GIFTY LAW

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend PII, per MD 9900 2/19/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death January 21, 2010 Physician/ Harvey J. Starkey 2:48 p. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Mt. Airy Kline Hospice House 8. Date of Birth (Month, Day, Yea June 30, g. Birthplace (State or Foreign . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 236-20-1038 1 x M 2 D F Hours West Virginia **1**923 86 June Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director Walkersville Yes 2 No Maryland Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò must be r 21793 Funeral USA 18 Georgetown Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

Yes 2 \[\sum \] No Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: "natural" Completed 3 Widowed 4 Divorced ntal Hygiene. ed other than "natura event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Education Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) alth and Mental h 27 is marked o er traumatic eve ၉ Ethel Hammond Harvey V. Starkey Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21793 18 Georgetown Road, Walkersville, Maryland Frances Starkey - wife Health 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1-26-2010 Frederick, Maryland Resthaven Memorial 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) METASTATIC LUNG CANCES Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c, If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the should be detached g Unknown a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown CHROME OBSTRUCTIVE WING DISEASE Division of Vital Records, Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Atrial Fibrillation s certificate has the lirector, page 2 s autopsy 2 1 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? HOSPICE HOUSE Hospital 1 ☐ Yes 2 ☐ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred I Director: After to in by the funeral Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital within 24 hours a To the Funeral Completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 29c. License number D 32171 22/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PO BOX 328 WALKERSUILLE 21793 RICUARD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 12 march

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 04340 State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Feb. 2010^a 1, 7:45 A M Marvell Beatrice Salley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Clinton Southern Maryland Hospital Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country) DC 1 M 2 X Months Days Hours Min. Sept. 13,1926 Director 579-26-0855 83 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location e filed within 72 Tours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5404 James Place NE 20019 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates African 1 ☐ Yes 2 X No Specify. Specify: 3 X Widowed 4 Divorced American 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Administrative Secretary Government Be 17. Father's Name (First, Middle, Last) th and Mental H 18. Mother's Name (First, Middle, Maiden Surname) Roscoe Montague t. Page 1 and 2 should entrement of Health and Mentertant: If item 27 is man enjury or other traumatile Ellen Lofty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Muriel H. Jackson/Daughter 5912 Oxon Run Parkway Forestville, Md. 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) February 2010 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o 1 XBurial 2 Cremation 3 Removal from State Lincoln Memorial 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland 21. Si mature of Funeral Service Linens le 22. Name and Address of Facility Stewart Funeral Home, 4001 Benning Rd. NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Lett Lower lube l'nommonia Physician disease or condition ু Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions. Examine Due to (or as a consequence of). ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Day 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Dementia with Sever Encephalopathy 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital Other: 10 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred eral Director: After filled in by the funer 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medica/Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Fune completed fi miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29c. License number 15+ 2010 Februan D 0055120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD PALMER MD 1328 Southern avenue Suite 310 Workington DC 20032 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 5 2010

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month Physician/ Medical 4b. City, Town, or Location of Death County of Deat **Examiner** Anne 9. Birthplace (State or Foreign . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** 1 M 2 XF (Month, Day, Year) 09/25/1939 70 **Director** Usual Residence of Decedent 10d Inside City Limits items 23a or 28a-f shov 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2 No Bowie MD Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number by Funeral USA 20715 16210 Oxford Court Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖁 No Specify: UNite Specify: Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Offices Medical Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Nellie Whites Frank P. Shutty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16210 Oxford Court, Bowie, MD 20715 Larry L. Shanks/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Lakemont Mem. Gardens 02/01/2010 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fulleral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. List Immediate Cause (Final Shall a Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine Due to (or as a consequence oi). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day 4 Pregnant at time of death 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 X 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 X No Certificate: To 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State)

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the state of the funeral Director. completed filled in by the funeral director, page 2 should be

State

DHMH 17 Rev 7/2009

Medical

29a. Certifier

(Check

31. Date filed (Month, Day, Year)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Date signed (Month, Day, Year) 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Physici	an	1. Decedent's Name (First, Middle, La	st)					2. Date of De Month	ath Day	Year	3. Time of Death
	/Medi			THER MARGAI	RET SCH	MITT			1	/29/2010		10:30 P M
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			152 CAM 5. Social Security Number 6. S	ELOT CIRCLE	n yrs. last birti	hday) If Und		BERLIN Under 24 Hrs.	8 Date of Bir	th		HESTER place (State or Foreign
	Funeral Director			1 □ M 2 🔀 F		rs. Month		ours Min.	8. Date of Bir (Month, Da	iy, Year) 0/1923	Coui	SSACHUSETTS
			Usual Residence of Decedent		00				11/1	0/1923	IVIAS	SACIOSETTS
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1	ith th	Director	10e. Street and Number			10f. 2	lip Code			10g. Citizen o	of What Cour	ntry?
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Box	death certi e attending id for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of p 1 Live birth 2 4 Pregnant at tim 9 Unknown	Fetal death	3 ☐ Ectopic 5 ☐ Other (I .	Date of deliv Month	ery Day Year
۵.	Physician: The law requires that the this certificate has been signed by the tail director, page 2 should be detached.		Part II. Other significant conditions	contributing to death but no	ot resulting in	the underlying	cause given in	Part I.	23e. Did t	obacco use co	ontribute to t	he cause of death?
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Division	or Atta	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Injury - building, etc. (5	At home, fari Specify)	m, street, facto	ry, office		28f. Location (City or To	Street and Nui wn, State)	mber or Rura	al Route Number,
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exam	nysiclan: To the best of miner: On the basis of example and manner stated	amination and	death occurre l/or investigation	on, in my opinio	date and place, on, death occur	and due to the ed at the time,	date and plac	manner as se, and due to	stated. o the cause(s)
	To the within 2 To the Comple	Me	29b. Signature and title of certifier			2	9c. License nur	mber	_	29d. Date sig	ned (Month	Day, Year)
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	9		30. Name and address of person who	completed cause of death	(Item 23a) (Type, Print)	Na	7	/ ^	0	2/8/1	<i>i</i>
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DHMH 17 Rev 1/2001

10-00662 Mary Taccino Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

fary Taccino	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 20 0											
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Funeral Director		5. Social Security Number 6. Sex 1 _ 1 _ M		s. last birthday)	If Under 1 Months		f Under 24Hr Hours Mir		2, 1921	Birthplace (State or Foreign Country)		
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Physician Medical Examiner		failur List only one cause or each lir mmediate cause (Final disease Hyp	_{e.} ertensive Atheros	clerotic Cardi						Approximate Interval Between Onset and Death		
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Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed							24a. Was autop perfo 1 ✓ Yes	osy prio rmed? dea	ere autopsy findings available or to completion of cause of ath? Yes 2 No		
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on of \ ending Phy ath. or: After th	۲	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year) FOUND: Jan 22, 2010	28b. Time of In FOUND: 1129 hrs	njury 28c	Injury at	t Work?		how injury occurred losed to low en			
Division of pital or Attending Phous after death. teral Director: After iffiled in by the funeral	Certification:	Z W Accident	28e. Place of Injury - A (Specify) Single Fa	t home, farm, stree	et, factory, of	fice build	ing, etc.	28f. Location (or Town, 5	Street and Number	or Rural Route Number, City		
To the Hospital within 24 hours To the Funeral completely filled	Medical C	29a. Certifier 1 Certifying Physician: 1 (Check only one) 2 Medical Examiner: On the and										
F 3 F 3	ğ	29b. Signature and title of certifier	(M)			C.M.E			January 23,	(Month, Day, Year) 2010		
Xb	f	30. Name and address of person who comp Melissa Brassell, MD Assist	eted cause of death (It ant Medical Exan		enn Stree	et, Balti	imore, MD	21201				
Sta Registi	ate	31 Date filed (Month, Day, Year) 2010	2. Registrar's Sign	ature de la	, ,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JAN 29 2010 **Physician** 1:14 A ELVIRA LOUISE TUCCINARDI /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MONTGOMERY BETHESDA NATIONAL NAVAL MEDICAL CENTER 9. Birthplace (State or Foreign Country)
New York 8. Date of Birth (Month, Day, Yea Sept. 30, If Under 1 Year | If Under 24 Hrs. Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔀 F Yrs 086-14-2294 88 Director Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State ral", or items 23a or 28a-f show Exarcher must be notified at 1 ☐Yes 2 MNo Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20902 2008 Glenallen Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ White 3€ Widowed 4 □ Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home es 1 and 2 should be filed wi of Health and Mental Hygier f item 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Reiff George Bertsch ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2008 Glenallen Avenue, Silver Spring, MD 20902 Anita L. Tuccinardi/Daughter Date 2, 20c. Location - City or Town, State permit. Pages 1 a
Department of He
Important: If item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Feb. 2 1 ☐ Burial 2 Cremation 3 ☐ Removal from State injury or Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Collins Funeral Home Inc. 21. Signature of Funeral Service Licenses 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician FRACTURE OF FEMUR WITH COMPLICATIONS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 2 month Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine executed My Hi system and Due to (or as a consequence of): burial-Box 68760 attending physician certificate be Physician/Medical the as IF FEMALE: 150 If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year for 5 Other (specify) P.0. ☐Yes 2 No the detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🛛 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1√2 Yes 2 □ No 1

Inpatient 2

ER/Outpatient 3

DOA Certification: To After this funeral c 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at 5 ☐ Pending investigation 1 Natural SUBJECT FELL 1 □Yes 2 No UNKNOWN M death. 2 Accident NOV 26 100 UNKNOWN " | 12 28e. lace of njury - it home, farm, street, factory, office building, etc. (Specify) To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2008 GLENALLAN AVE 3 Suicide 4 Homicide SILVER SPRING MD 20902-1373 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and minner stated. 29a. Certifier Medical (Check only

(10

one)

CARL W.

31. Date filed (Month, Day, Year)

FEB

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CDR MC USNR

32. Registrar's Signature

PETERS

29b. Signatury

Registrar DHMH 17 Rev 1/2001 park

29c. License number

MEOO47374 (FL)

NATIONAL NAVAL MEDICAL

BETHESDA MD 20889-5600

29d, Date signed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Joseph Edward Talbot, Jr. 8:52 pm Physician/ January 23, 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Funeral June 29 Year) 1940 1X M 2 D F Months Days Hours Connecticut 69 218-38-5409 **Director** Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 20852 10401 Grosvenor Place, Apt. 421 or items 23a death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ within 72 hours after 21215-0036 White 1 Yes 2 X No Specify: permit. Page 1 and 2 should be filed within 72 hours afti Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar If Yes, Give 3 Widowed 4 Divorced Specify. Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Economist (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Grace Cleary Joseph Edward Talbot 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16400 Equestrian Lane, Derwood, MD 20855 Grace Talbot Bryn/Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Jan. 2010 Metropolitan Crematory Alexandria, Virginia 21. Signatur of uneral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition teroscleratic cardiovasculas Physician Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Year Pregnant at time of death Day signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed cate has been sig ; page 2 should t 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? this certificate 1 Yes 2 No 2 **X**No To the Hospital or Attending Physician: within 24 hours after death. ▼To the Funeral Director: After this certifical completed filled in by the funeral director, I **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA ဂ္ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 XXCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 55410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600010 6600 ge four 6 , Bohesa RS

State Registrar 31. Date filed (Month, Day Year) JAN 28 2010

205

George town

. Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For AMEND#17perINI State AMEND#26p erM	State (5,2/3/10, H	w,Ma	ryland /	Depa Cen	irtment of l tificate of l	tealth Death	and M	lental Hy	giene	201	7	NL31	16
			1. Decedent's Name (First, Middle,	ast)	TOANA T	<u>vico</u>					Date of Dea	ath	<u></u>	Ť	3. Time of Dea	th
	Physicia Medic		Mary Daniel Tur	ner							January	27,	2010 ^{Year}		4:03 a	М
	Examin		4a. Facility Name (if not institution, g Sanctuary at Holy		nber)			4b. City, Town, o		of Death			County of De			
-11-6	Funeral			. Sex	7. Age	(In yrs. last b	oirthday)	If Under 1 Year	If Unde	er 24 Hrs.	8. Date of Birt	h			ce (State or For	reign
	Director		214-56-0524	1 □ M 2 🕱 F	84		Yrs.	Months Days	Hours	Min.	(Month, Day Nov. 21,	, Year) 1925		D.C.		
	d low it	ı	Usual Residence of Decedent 10a. State 10b. County			10c. City, To	wn or Loc	ation	_					100	I. Inside City Li	mits
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	or 28,	Dire	D.C. – 10e. Street and Number			wasim	iguai	10f. Zip Code			T	10g. Citiz	en of What	Country		
	with t	Funeral Director	1212 Madison Stre	et, NW				2001	.1		τ	JSA				
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at once.	ģ	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	If Yes, Giv	rces? 2 ⊑ x N ∕e		If	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 No	n, Mexic	an, Puerto	cify Yes or No- Rican, etc.)		4. Race - An Biack, Wh			
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Maryland 21215-0036	2 should Ith and IN 27 is ma trauma		19a. Informant's Name/Relationship Mary E. Suplee, SND,			1		g Address (Street					own, State,	Zip Co	de)	
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	nysician/ ≱ Medical		disease or condition resulting in death)	_ a		consequenc		ne netasta	5.15					+	yrs —	
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89	ending	by Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou 1 ☐ Live	come of	f pregnancy	ath 3	Ectopic pregnan	CV			2	3d. Date of o			
80	death he att	/sici	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4 ☐ Preg 9 ☐ Unk		time of deat	h 5 🗆	Other (specify)					Month	D	ay Year	
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Sioi	Attend death ctor:	ıili Liji	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	t be	of Injur	y - At home,	farm, stre	et, factory, office	165 21	-	28f. Location (S	treet and	Number or F	Rural R	oute Number,	-
Division of Vital Records, P.O. Box 68	al or / s after al Dire		4 - Homicide determin	ed build	ng, etc.	(Specify)					City or Tow	n, State)				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 124 hours atterdeath. To the Funeral Director Atter this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying F (Check 2 Medical Ex	aminer: On the ba	sis of exa	amination and	d/or invest	igation, in my opini	on, death	occurred at	the time, date a	nd place, a	and due to th	e cause	e(s) and manner	stated.
	the ithin 2 the orther comple	ž	only one) 3 Certifying N 29b. Signature and title of certifier	lurse Practioner:	To the b	est of my kno	owledge, d	eath occurred at the 29c. Licens					and manner signed (Mo			
	10		Barbara /	upmain	48	SM A	1		065)	127	,		
			30. Name and address of person wh	o completed cau							ın		,	(240		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Terry Neil Tesar January 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery Age (In yrs. last birthday) Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 - F Months Hours (Month, Day, Year, Director 327-34-5956 67 Ĩ943 Illinoi Usual Residence of Decedent 10b. County 10c. City. Town or Location with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland | Montgomery Gaithersburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6 Garfield Court 20882 within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ð 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify "natural", 3 Widowed 4 Divorced Specify: Completed Year or Dates. 1964-68 White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. United States National College (1-4 or 5+) Elementary/Seconday (0-12) 5+ Management Analyst Park Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H ၉ pe George (NMN) Tesar I and 2 should b FHealth and Mer Item 27 is mark <u>Helen Kristak</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to Linda G. Tesar, wife Garfield Court, Gaithersburg, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 1/28/2010 Silver Spring, Maryland 21. Signature of Funeral Se 22. Name and Address of Facility Molesworth-William Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 Approximate Interval Between Onset and Death Physician, Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to in mediate cause. Enter Underlying Cause (Disease or linjury that initiated events Intravascular coaqulation burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of resulting in death) Last the attending physician hed for use as the burial Physician/Medical coucer IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 1 Yes 2 L 9 Unknown 2 🗌 No 9 Unknown Division of Vital Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has autopsy director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

10 +1 VA

arke

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Rose Ann Taylor January 2010 10:01A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Care Baltimore Towson 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 1 🗆 M 2 🛛 F Months 3^M30-1^y9²5 Georgia Director 579 36 7462 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyes 2 No MD Howard Ellicott City 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral filed within 72 hours after death with 8260 K Stone Crop Drive 21043 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ Yes 2X No Yes, Give Maryland 21215-0036 1 Yes 2 No Specify. 3 ₩ Widowed 4 □ Divorced Specify: "natural" Completed White Year or Dates permit, Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Branch Manager Bank of America 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John R. Davis Lois Beall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bette A. Taylor/Daughter 8260 K Stone Crop Drive Ellicott City, MD 21043 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 2-17-2010 Arlington Nat'l Cem. Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lipensee M00845 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a c Jud quence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 XXIO

9 Unknown Month Vear Day Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown Records, Completed 1 🗌 Yes 2 No 3 Probably page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed certificate 1 ☐ Yes 2 ☐ No 2 within 24 hours after death.

To the Funeral Director; After this certifics completed filled in by the funeral director, I Physician: 25. Was case referred to medical To Be of Vital 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \)Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Dath 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: 28b. Time of 28c. Injury at Hospital or Attending Natural 5 Pending Division 1 Yes 2 No Investigation 6 Could not be Accident Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one the 29b. Signat and title of certifie 2 29c, License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

		State of Maryland / Department of Health and Mental Hygiene of State of Maryland / Department of Health and Mental Hygiene of State of Maryland / Department of Health and Mental Hygiene of State of Maryland / Department of Health and Mental Hygiene of State of Maryland / Department of Health and Mental Hygiene of State of Maryland / Department of Health and Mental Hygiene of State of Maryland / Department of Health and Mental Hygiene of State of Maryland / Department of Health and Mental Hygiene of State of Maryland / Department of Health and Mental Hygiene of Maryland / Department of Health and Mental Hygiene of Maryland / Department of Health and Mental Hygiene of Maryland / Department of Health and Mental Hygiene of Maryland / Department of Health and Mental Hygiene of Maryland / Department of Health and Mental Hygiene of Maryland / Department of Health and Mental Hygiene of Maryland / Department of Health and Mental Hygiene of Maryland / Department of Health and Mental Hygiene of Maryland / Department of Health and Mental Hygiene of Maryland / Department of Health and Mental Hygiene of Maryland / Department of Health and Mental Hygiene of Maryland / Department of Health and Mental Hygiene of Maryland / Department of Health and Mental Hygiene of Maryland / Department of Health and Mental Hygiene of Maryland / Department of Health and Mental Hygiene of Maryland / Department of Health and Mental Hygiene of Maryland / Department of Health and Mental Hygiene of Men	2010	04349
Physicia		1. Decedent's Name (First, Middle, Last) Eva Mae Turner 2. Date of Death Month Day JAN 31 St	Year 2010	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	County of Death	
Funeral Director		Patrixent River Healit & Rehab. Lawrel 12 15.408.546 Hy 1639 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 160.5 Hours Min. (Month, Day, Year) 160.5 Hours Min.		lace (State or Foreign
e Maryland ta-f show	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10c. City,	10	0d. Inside City Limits 1 Yes 2 □ No
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ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. To f Health and Mental Hygiene. To fleath and Mental Hygiene. To other traumatic event, the Medical Ever in a must be notified a controller.	by Funeral	If Yes, Give 1 Light 2 MNo Specify: S 3 □ Widowed 4 □ Divorced Year or Dates:	4. Race - America Black, White, e Specify:	
within 72 he iene. than "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) One of the property of the proper	d of Business/Ind	dustry
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Definition 5. West yield with premint. Pages 1 and 2 should be filled with Department of Health and Mental Hygiene. Important: If flem 27 is marked other than any Injury or other traumatic event, the page.		19a. Informant's Name/Relationship (Type. Print) Grand Vacquity 19b. Mailing Address (Street and Number or Fural Route Number, City or The Unit 100 100 100 100 100 100 100 100 100 10	boro, 1	11) 20121
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permit. Departi Importa any Inji		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wells Funeral MS 390	669	
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/Medical Examiner		resulting in death) Due to (or as a consequence of): Cevebro yasular occident b.		Years
ficate be executed physician and sthe burial-transit	Examiner	resulting in death) Last Sust Cords a consequence of): Last Cords a consequence of): Last Cords a consequence of): Due to (ords a consequence of): Due to (ords a consequence of):		Years
	edical	d		
The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as to	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown	3d. Date of delive Month	ery Day Year
quires that an signed by	þ	So Solver and the significant conditions continuously to deally out not resulting in the universitying cause given in Part i.		ne cause of death?
The law requir	Completed	24a. Was an autopsy performed? 1 □ Yes 2 ⊠No	24b. Were autoprior to condeath?	psy findings available mpletion of cause of
sician: Th certificate irector, pag	o Be	25. Was case referred to medical examiner? Hospital: Cothor:	Dotter (0, 11)	
Attending Physician: r death. ector: After this certifica by the funeral director, p	\vdash	27. Manner of Death 1 Matural 5 Pending (Month, Day, Year) 28b. Time of Injury Work? 1 Pending investigation 1 Yes 2 No		y)
To the Hospital or Attendin within 24 hours after death to the Funeral Director: Aft completely filled in by the fun	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and City or Town, State)	Number or Rura	il Route Number,
ne Hospi n 24 hou ne Funer pletely fil	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) a construction of the cause (s) and manner stated.		
To t with To tl	Ž	29b. Signature and title of certifier 29c. License number 29d. Date D 53i4II	signed (Month,	Day, Year)
1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J She Sadri 14300 Gallant Fox Lo 1= 210 Bowie MD 20715		
Sta Registr	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 0 4 2010 Chara S. Agare		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:00 Raymond Ernest Twomey anuary 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Lanham Doctors Community Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 **X** M 2 □ F Hours (Month, Day, Year) 12/14/1913 Months 96 Director 007-01-8634 Maine Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 X Yes 2 No MD Prince George's Bowie 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ò Funeral items 23a 2701 Felter Lane 20715 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after death 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☑ No Black White etc. and Mental Hygiene. is marked other than "natural", or 1 Never Married 2 Married ģ Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give 3 Nidowed 4 □ Divorced Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Specialist US Postal Service 12 pace and Equipment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Corinne Gonneville Jeremiah Leo Twomey permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Corinne Call/Daughter 2629 Felter Lane, Bowie, MD 20715 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 K Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Laurel Hill Cemetery 01/30/2010 Saco, Maine 21. Signature of Fur eral Service Licens 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEDSI disease or condition resulting in death) unknown Medical Medica. Examiner im known inflanction Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or iinjury Examine Due to lors physician and the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the a a Hinknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 has 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to predical 26. Place of Death (Check only one) Be examiner? 2 10 No Hospital Other: 1 🗌 Yes 1 Inpatient မ 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 24 hours after death.

Funeral Director: After thi leted filled in by the funeral 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29b. Signature and title of certifier AM MD W 18 00060120 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 Mitchellville Rd #B-216 Bowie MD 26716 W. Hagothma 31. Date filed (Month, Day, Year) State FEB 01 2010 Registrar

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	//aryland 8a-f show tified at	Director	Usual Residence of Decedent 10a. State 10b. Cou MD Prin		10c. City, Tov Landov					10d. Inside City Limits 1\%\X\X\Yes 2 □ No			
	with the I s 23a or 2 ust be no	Funeral Di	10e. Street and Number 7411 Allison	Street			10f. Zip Code 20784			log. Citizen of What Co lexico	untry?		
980	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Merital Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 ☒ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Divo	If You Give	SS? X No	If	Vas Decedent of Hi Yes, specify Cubar	n, Mexican, Puerto	erto Rican, etc.) Black, White, etc.				
Baltimore, Maryland 21215-0036	ithin 72 hou ene. • than "natu he Medical	Completed by		cedent's Education highest grade completed) 12) College (1-4	or 5+)	(Give k	ent's Usual Occupa kind of work done d O NOT use retired)	ation luring most of worki	ng	16b. Kind of Business	ndustry		
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more,	permit. Page 1 and Department of Her Introctant: If item an injury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crema: 4 ☐ Donation 5 ☐ Oth	ation 3 ☐ Removal from S	cemet	erv. crem	sition (Name of natory or other place nes Cemet	e) i		20c. Location - City or rande, 0axa			
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. Box 68760	g e	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 🔲 Live Bi	int at time of death		Ectopic pregnanc Other (specify)	у		23d, Date of de Month	ivery Day Year		
ds, P.O.	v requires that the state of th		Part II. Other significant con	nditions contributing to dea	ith but not resulting	g in the u	nderlying cause giv	en in Part I.	23e. Did tob	bacco use contribute to	the cause of death?		
Division of Vital Records,	The lavate has	Completed by							24a. Was a autops perfori 1 Yes	med? prior to death?	topsy findings available completion of cause of		
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Divisi	tal or Atters after de al Directo	Il Certificate:			f Ir jury - At home, , etc. <i>(Specify)</i>		eet, factory, office		28f. Location (St City or Town	reet and Number or Run, State)	ral Route Number,		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.	Medical	(Check 2 → Medi only one) 3 → Certi	fying Physician: To the besical Examiner: On the basis fying Nurse Practioner: To	of examination and	or invest	tigation, in my opinio	on, death occurred a	t the time, date an ce, and due to the	nd place, and due to the cause(s) and manner as	cause(s) and manner stated.		
	To the I within 2 To the I complex		29b. Signature and title of cer	ertifler	to Do		29c. License			Esouthy 3			
R	4		30. Name and address of per	Vester 30	of Hosp	1/2	Print) Drive	Cheve	16	umy las	sd		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ ime. 32 AM Medical 4a. Facility Name (if not institution, give street and num 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Prince George's Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days 1 ★ M 2 □ F Months Hours Min. **Director** 577 64 1965 03 /06/1947 Wash Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location the Maryland notified at 10d. Inside City Limits Director MD Prince George Clinton 28a-f 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ral", or items 23a o Examiner must be permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b Completed by Funeral 9909 Wooden Bridge Lane 20735 US 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican. etc. Armed Forces Black, White, etc. 1 ☐ Yes 2 ☐ Mo If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Wright, Sr. Myrtle Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sophia Wright/wife 9909 Wooden Bridge Lane Clinton, MD20735 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 4 Donation 5 Other (Specify) Resurrection Cem. 2-4-2010 Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington Rd Waldorf 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final PULMONA Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant a 9 Unknown Pregnant at time of death 5 Other (specify) signed by the a 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? this certificate 1 Yes 2 No Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖾 No ၉ 1 ☐ Inpatient 2 🖾 ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 X Natural 5 Pending 2 🗌 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one and title of certifier 29b. Signature 29d. Date signed (Month, Day, Year, MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar NYGJIAKA

2010

31. Date filed (Month, Day, Year)

FEB02

FARKUAY GREETEBELT MARYLAND 2077D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 24, 2010 Anna Louise Wise 2:10 рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brooke Grove Nursing Home Sandy Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🏲 F Months Days Hours Jun.9, Year) Maryland 212-16-2590 98 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 Yes 2 No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3687 South Leisure World Blvd. 20906 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 5 Black, White, etc. ģ within 72 hours after 1 Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural", If Yes, Give Specify: White Completed 3 ₩ Widowed 4 □ Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Jarrett Nelson Shauck Eleanor Mabel Whitney permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print)
Mary R. Wise/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14118 Buckhill Court, Burtonsville, MD 20866 Date 28 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan. 28 2010 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State John's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Eliter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Myocardial Infarction immediate Medical Due to (or as a consequence of): Examiner Debility 6 months Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): physician and the burial-transit Exam Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ cate has been signated; Completed 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No Yes 2 TKING the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Yes ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate; 28d. Describe how injury occurred Natural 5 Pending after death. Accident Investigation 1 Yes 2 🗌 No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie To the Hosp within 24 ho To the Fune completed fi 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatur and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) -0 D35045 January 25, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Philip Henjum, MD 18109 Prince Philip Drive, #200, Olney, MD 20832 Year 6 31. Date filed (Month, Day,

State Registrar 32. Registrar's Sigrature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician Month 21:16 Tammy L. Whittington January 20, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Months 1 □ M 2 🛭 F Director 219-86-2248 14, Dec. 1970 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location show ed other than "natural", or items 23a or 28a-f sho event, the "tedical Examiner must be notified at 1 Yes 2 No Director MD Gaithersburg 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? illed within 72 hours after death with 16613 Raven Rock Drive 20878 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ If Yes. Give Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 12 should be filed w h and Mental Hygiel 7 is marked other th <u>Office Manager</u> Veterinarian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tommy Robey Nancy Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20878 Pages 1 and 2 s. ment of Health a Ed Whittington/Husband 16613 Raven Rock Drive Gaithersburg, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 1-25-2010 Falls Church, VA 22. Name and Address of Facility Edward Sagel Funeral Direction, 21. Signature of Funeral Prvice Lice Kurt Blake M01477 1091 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiac Arrhythmia Minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Acute Corinary Syndrome Hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sician and burial-transit the death certificate be executed Exami Coronary Artery Disease Years Due to (or as a consequence of): Box 68760 attending physician Physician/Medical for use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 □ Yes 2 😾 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 🖺 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

P.O. Division of Vital Records. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p.

29a, Certifier 1 🛱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number

29d. Date signed (Month, Day, Year)

30. Name are address of person who completed cause of death (Item 23a) (Type, Print)

James McQuiston MD 9901 Mediacl Center Drive. Rockville, Maryland 20850

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04355 State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January Roland Joseph Workman 31, 2010 9:10 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 14927 Hydrus Road Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Feb. 25, 1915 Hours New Jersey 216-44-9230 Director 94 Yrs. Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Numbe 10g. Citizen of What Country? Funeral 14927 Hydrus Road 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filed within 72 hours after deat the and Mental Hygiene. 27 is marked other than "natural", or iter traumatic event, the Medical Examiner. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes Yes, Give 2 🛛 No 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Assistant Director of Federal Government 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Workman Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Mary M. Workman/Personal Rep. 14927 Hydrus Road, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or o ☐ Burial 2 Stremation 3 ☐ Removal from State cemetery, crematory or other place Metropolitan Crematory 4 Donation 5 Other (Specify) 2010 Alexandria, Virginia 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, Md 20901 21. Signature of Funeral Service Licenses Alleson Mi 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Congestive Heart Failure Medical resulting in death) Due to (or as a consequence of): Examine Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or linjury that initiated events Dilated Cardiomyopathy Due to (or as a consequence of): resulting in death) Last physician a s the burial-Physician/Medical that the death certificate be attending p IF FEMALE: yes, outcome of pregnancy ☐ Live Birth 2☐ Fetal death 3☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Mitral Regurgitation cate has been sig 1 ☐ Yes 2 🗗 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 2 No 1 Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 K No ည 1 Inpatient 2 ER/Outpatient 3 DOA e Hospital or Attending Phy: n 24 hours after death. e Funeral Director: After this leted filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury Work: 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hin 24 hours af the Funeral Di πpleted filled ir cal 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D58962 2/1/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18121 Georgia Avenue, #103, Olney, MD 20832 Shashank G. Patel, MD 31. Date filed (Month, Day, Year) Registrar's Signature Registrar

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar			State of	f Maryla		partment ertificate		lealth and N Death	Mental Hy	/giene	2010	0 01	358
	Physici /Medic		1. Decedent's Nan Robert		e, Last) oodwa	rd						2. Date of D		201 ⁶ ar	3. Time 11	of Death :55p _M
1	Examin		4a. Facility Name Renaissar					llage		,	r Location of Death Spring		4c. 0 P.0	County of Dea	ath	
	Funeral Director		5. Social Security 232–22–69		6. Sex	/ 2□ F	7. Age (In y	rs. last birthd 9 Yrs	Months	Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D July 6	ay, Year)	9. Bi	rthplace (Sta Country) st Virgi	te or Foreigr nia
	pu ,		Usual Residence												T	
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	with the	Direc	10e. Street and Nu		D4	7	IOF.		10f. Zip (en of What C	country?	
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evandract, until he medilled at	by Funeral Director	11. Marital Status 1 □ Never Mar	rried 2 🛣 Man	12	. Was Dece Armed For Marries If Yes, Giv	dent Ever in rces? 2 \(\) No				lispanic Origin? (Span, Mexican, Puerto	pecify Yes or N Rican, etc.)		4. Race - Am Black, Whi Specify: V		,
21215-0036	hin 72 hou e. an "natur : Medical I	Completed by	(Spe	15. Deceden	t's Educa st grade d	tion completed)	-4or 5+)	(G	cedent's Usual ive kind of work e. DO NOT use	done d	during most of work	king	16b. Kin	d of Business	s/Industry	
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Maryland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Ma	To Be	17. Father's Name Royal S.	. <i>(First, Middle,</i> . Woodwar	_						18. Mother's Nam	,	e, Maiden S	Surname)		
Mar)	nd 2 sho alth and I 27 is ma r trauma	10	19a. Informant's N Betty J. V			. Print)					and Number Ru Road, Silve				Zip Code)	
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau			sposition Cremation 5 Other (S		noval from S			sposition (Name rematory or other tan Crem			Date 0. 1, 010		ation - City or		
Balti	permit. Departm Importal any inju		21. Signature of F			22			22. Name and Francis	Addres	ss of Facility Ollins Fune ty Blvd. W.	ral Home	Inc.			
	Physician /Medical Examiner	Examiner	23a. Part 1. Ent. shock, or h Immediate Cause disease or condition resulting in death) Sequentially list or if any, leading to ir any, leading to ir cause (Disease o Cause (Disease o Cause (Disease o Cause (Disease o	ert failure. List	complica only one a. b.	Recurr Due to (ach line. cent Bl: or as a cons	eath. Do not adder Casequence of):		of dyin	g, such as cardiac	or respiratory	arrest,		Approxir Interval Onset ar	nate Between nd Death
	ficate be executed physician and s the burial-transit	dical	that initiated event resulting in death)	IS .	c	Due to (or as a cons	equence of):								
P.O. Box 6	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	Physician/Me	FFEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknown	2 months? □No	230	1 Live b	come of pre- pointh 2 Finant at time of cown	etal death	3 ☐ Ectopic pre 5 ☐ Other <i>(spe</i>		у		23	3d. Date of de Month	elivery Day	Year
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of	Physician: r this certificaral director, p	ပ္	1 Yes 2		-		·		tient 3 DOA	_1	4 to Nursing Fit				ecify)	
Division	arth. rr: After	Certification:	27. Manner of Dea 1 Natural 2 Accident 3 Suicide	ttn 5	gation		of Injury h, Day, Year		y M		yat ⟨? Yes 2 □ No	28d. Describe				
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	o the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only one)	1 ⊡ C ertifyin 2☐ Medical	g Physic Examîne	ian: To the r: On the ba and mann	asis of exam	(nowledge, de ination and/o	eath occurred a r investigation,	t the tir in my o	ne, date and place pinion, death occur	, and due to the rred at the time	cause(s) ; , date and p	and manner a place, and du	as stated. ie to the caus	e(s)
	within 2 To the comple	Σ	29b. Signature and	d title of certifier		Put) \	ans	29c.	License	number D59524			signed (Mon ruary 1,)

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31. Date filed (Month, Day, Year) FEB 0 3 2010 State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loveen Puthumana, MD 3110 Gracefield Road, Silver Spring, MD 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:00a M White Tony Tan 28 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Months Hours 256-80-0942 53 107057 1956 Georgia Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at ld be filed within 72 hours after death with the Maryland Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20902 12031 Claridge Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Yes 2 No.1974 Yes, Give Black, White, etc. 1 Never Married 2 😾 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ➡ No Specify: "natural", Specify: 3 Divorced 4 Divorced White Completed Year or Dates event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Warehouse work Vegetable Co. and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 White unknown unknown permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print)
Angelica White/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12031 Claridge Road Silver Spring, Md20902 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗌 Burial ₽ 😾 Cremation β 🗆 Removal from State 2/02/2010 4 Donat 6n 5 🗆 Other Sbecify) Chesapeake Crem Beltsville, Md 21. Signature PHILIPAdds RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he if failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Metabolic encephalopathy disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Carcinomatosis meningitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner physician and s the burial-transit Metastatic prostate cancer Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy death? certificate 1 ☐ Yes 2 🔀 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? in 24 hours after deatn. The Funeral Director: After this of anleted filled in by the funeral dire မ 1 Yes 2 🔀 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural Natural 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 😾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗍 within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Jan.29,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nabila Khan M.D.

Registrar DHMH 17 Rev 7/2009

State

31. Date filed Weeth

1500

32. Registrar's Signature

Forest Glen Road Silver Spring, Md 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 29, 2010 Mary Louise Wack 6:00 p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care-Potomac Potamac Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 M 2 M F Hours Min May 6, 1925 579-26-1696 Virginia Director 84 Usual Residence of Decedent Show 10b. County filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Potomac 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8321 Turnberry Court 20854 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 27 Is marked or traumatic ever .. Page 1 and 2 should be fill treent of Health and Mental tant: If item 27 is marked or ρ Arthur Davis Ruby Insley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrisha Davis-Coupe/Daughter 8321 Turnberry Court, Potomac, MD 20854 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State Feb 2010 Silver Spring, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses francing Address of Fully Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Advanced Dementia disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autopsy 1 Yes 2 No 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 X No Other: |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 V Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Matural filled in by the funeral Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, within 24 hours af

To the Funeral D

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D54566 2/1/2010

Registrar
DHMH 17 Rev 7/2009

State

areas

9801 Georgia Avenue, Silver Spring, MD 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Sunitha Bhogavilli, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ January 26. William Wolf 2010 5:30 A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery 800 Amber Tree Court #202 Gaithersburg If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign al Security Numbe 7. Age (In vrs. last birthday) 8. Date of Birth 6 Sex **Funeral** Aug. 16, 1919 579-10-7187 1 M 2 F New York Director 90 Jsual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. Montgomery Gaithersburg 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 800 Amber Tree Court 20870 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No WWII If Yes, Give Year or Dates. Army 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Parts Store 0wner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Wolf Jenny Hurwitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas Wolf / son 44 Beacon Hill Court, Gaithersburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Mt. Lebanon Cemetery 01/28/10 1 Burial 2 Cremation 3 Removal from State Adelphi, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Licensee Porchitisky Hebrew Funeral Home 254 Carroll St., NW. Washington, DC 20012 23a. Part 1. Differ the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pancreatic Cancer disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical ding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Ischemic Heart Disease, Sick Sinus Syndrome, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Cancer of Colon, Hypertension, Diabetes autopsy performed 1 ☐ Yes 2 ☐ No Yes 2X No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No. 5 Pending 2 Accident Investigation Suicide 6 Could not be 3 🗀 Suiciae 4 🗌 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier ٌ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the F within 2. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 27301 January 26, 2010

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JAN 28 2010

Box 68760

P.O.

20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Douglas R. Shumaker, M.D., 615 W. Montgomery Ave., Rockville, MD

62. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 04360 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Helen Wagner January 27, 2010 Year 5:45 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Silver Spring Montgomery Aspenwood Senior Living Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗗 F Months Days Hours Min. NOV. 189, Yell 20 Pennsylvania 89 277-16-6976 **Director** Usual Residence of Decedent 28a-f shov 10b, County 10a. State 2 should be filed within 72 hours after death with the Maryland this and Mental Hygiene.
It is marked other than "natural", or items 23a or 28a-f sho is marked other than "natural", or items 5as or 28a-f sho r traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🏝 No Maryland Silver Spring Mon topmery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 14400 Homecrest Road, Apt. 45 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 🔀 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Malay Helen Babin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Diane M. Salem/Daughter 15500 Scotch Heather Court, Rockville, MD 20853 Date 30, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 x Burial 2 Cremation 3 x Removal from State Jan. 2010 St. Joseph Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Tiffin, Chio 21. Signature of Fungral Service Lie Francis J. dres fins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Bladder Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of): death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last anding physician a use as the burial-Physician/Medical Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) Month Dav Year Pregnant at time of death Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Rheumatoid Arthritis, Vaginal Cancer Division of Vital Records, icate has been siç r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X N 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, p. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 🗵 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify, 2 X No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 \square Pending 1 A Natural injury 1 Yes 2 No М Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Philip Schwartz, MD 15225 Shady Grove Road, Rockville, MD 20850 31. Date filed (Month, Day, Year) JAN 28 2010 32. Registrar's Signature State Registrar

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | | 04361 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month tem it ton 7 PM Ernest Whies Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 12102 Judson Road Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Country) Maryland 1 **⊠** M 2 □ F Months Days Min. July 8, 1927 579-32-2996 82 Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must <u>be notified at.</u> 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Maryland 1 ☐ Yes 2 To No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12102 Judson Road 20902 TISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1

Yes 2 □ No Black, White, etc. 1 Never Married 2 Married <u>6</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Year or Dates, 1945–47 Specify: White 3 K Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) US Government should be filed within 7 h and Mental Hygiene. 7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Book Binder Printing Office Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ Ernest H. Wines Beulah M. Knisley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Wines/Son 1 and 2 s if Health a item 27 i 12111 Aspenwood Lane, Laurel, MD 20708 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 20c. Location - City or Town, State 1 🛣 Burial 2 □ Cremation 3 □ Removal from State Feb. 1, 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, Maryland 21. Sign 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or como shock, or heart failure. List only on tations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ecause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ As th disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): Exami attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death the q 🗌 Unknown g 🗌 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy page certificate 1 Yes 2 No Yes 2 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) D MD 29018 28/10 Betsy Ballard, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Silver # 30 Y Park Dr. 2101 Medical 31. Date filed (Month, Day, Year) 82. Registrar's Signature. State 2 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Raymond Francis Ward /Medical 01 2010 3:45 a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pocomoke City

If Under 24 Hrs. Hartley Hall Nursing Home Worcester 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 XM 2 ☐ F 98 Director 3/1/1911 213-14-1180 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 21 No Director MD Pocomoke City Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or ? r must be r 1948 Cedar Hall Road 21851 **USA** Funeral r than "natural", or items the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No ģ Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Bridge Tender Local Government marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) tem 27 Is marked oth Be ပ Archie Ward Bertie Townsend 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr Pat Bundick (daughter) 1949 Cedar Hall Rd., PocomokeCity, MD 21851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Remson Methodist Cem. 2/1/2010 Pocomoke City, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Fugeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home, Professional Association 107 Vine St., Pocomoke City, MD 21851 Run 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Theroscher dioner **Physician** /Medical Due to (or as a consequence / f): Examiner Sequentially list conditions, in any, issuing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for sels noneaquants off Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2. No page 2 1∐ Yes Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t or Attending 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 1 24 hours after death.

• Funeral Director:

• oletely filled in by the fi death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a/) Type, Print) ecomoke Market

Registrar ———

State

31. Date filed (Month)

DHMH 17 Rev 1/2001

parke

32. Registrar's Signature

10-00799	
Calvin Woodland	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 04363

		1- For State Certificate of Registrar	Death	Re	eg. No.	
Physici ledical Exami	an/	1. Decedent's Name (First, Middle,Last) CALVIN WOODLAND		2. Date of Deat Month January 2	h Day Year	3. Time of Death 2320 hrs
		4a. Facility Name (if not institution, give street and number) Prince Georges Hospital Center	c. City, Town, or Location of Cheverly	of Death	4c. County of Death Prince George'	s
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 577-21-8165 1 X M 2 F 18 Yrs.	If Under 1 Year If Under Months Days Hours		th(MM/DD/YYYY) 9. Birth / 1991 Foreign Cou	
d now any		Usual Residence of Decedent 10a. State 10b. County Maryland Prince George's 10c. City, Town or Locatio 0xon Hill Washington				10d. Inside City Limits 1 Yes 2 X No
he Maryland 1 or 28a-f show ified at once.	Director	10e. Street and Number 1355 Southview Dr. #203 844 Barnaby St. SE #202	10f. Zip Code 20745 20032	10	Dg. Citizen of What Count USA	try?
215-0036 be filed with the Maryland man Hygiewith 72 hours after death with the Maryland man Hygiewith than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? If Yes 2 X No	Decedent of Hispanic Orig s, specify Cuban, Mexican		14. Race - Americ White, etc.	an Indian, Black,
hours after 'natural'', C Examiner :	by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's	Yes 2 No specify: s Usual Occupation (Give st of working life. DO NOT		Specify: B1 16b. Kind of Business/In	ack
MD 21215-0036 A2 should be filed within 72 hours thand Mental Hygiene. n 27 is marked other than "matu numatic event, the Medical Exam	Completed		loyed 18.Mother	's Name (First, Middle, M	None	
21215-003 uld be filed withi Mental Hygiene, marked other tt	Be	Calvin Woodland	Cece	elia Woodla		Zin Code)
MD 21 ad 2 should but and Mer an 27 is mar	7	Cecelia Woodland - Mother 1355 S	outhview Dr	#203 Oxo		20745
Baltimore, MD 2121 permit Pages 1 and 2 should be fill Departite Pages 1 and 2 should be fill Important: If item 27 is marked injury or other traumatic event,		1 X Burial 2 Cremation 3 Removal from State Resurrecti	on Cemetery	Date 2-2-2010	Clinton, M	·
Balt permit. Departs Import		VICURINE WILLOWARD 1430	me and Address of Facility Shall's Fund 8 Suitland	Rd. Suitla:	nd. Md. 2074	
Physician /Medical Examiner		Part I. Enter the disease, or complications that caused the death. Do not enter the failure, List only one cause on each line. Immediate Cause (Final disease	e mode of dying, such as c	ardiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
	L	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.				
, i	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury triat inflitted events resulting in death) Last	.12.7			
760, cate be executed physician and he burial - transit	Medical E	UNPENDED X AMENDED #10a-f,perINF,G	901,3/5/2010),WS		
687 ertifi ding e as t	sician/Me	past 12 months? 4 Pregnant at time of death 5 Other	al death 3 Ectopio	c pregnancy	23d. Date of delivery Month Da	ay Year
	by Phys	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Pa		bacco use contribute to the 2 ✓ No 3 Proba	
cords law requ has been 2 should	Completed			24a. Was a autop	an 24b. Were auto sy prior to co med? death?	opsy findings available ompletion of cause of
tal Recitant: The certificate		25. Was case referred to medical	26 Place of Death	(Check only one)	2 No 1 ✓ Yes	8 2 No
Vita ysician his cer directo	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient	3 DOA Other4	Nursing Home 5	Residence 6 Other:	
Sion of Attending Ph. death. ctor: After tly the funeral	шы	27. Manner of Death 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 2254 hrs	ury 28c. Injury at Work	Subject shot	now injury occurred	
Division Hospital or Attendia 24 hours after death. Funeral Director: A	Certification:	3 Suicide 6 Could not be determined (Specify) Parking Lot	, factory, office building, et	or Town, S	Street and Number or Runtate) Street SE, Washington	
Di To the Hospital within 24 hours a To the Funeral I completely filled	Medical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	ed at the time, date and place, in my opinion, death oc	ace, and due to the caus courred at the time, date	e(s) and manner as state and place, and due to the	d. e cause(s)
F ≯ E S	Me	29b Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Mon January 28, 2010	
R5		30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 I	Penn Street, Baltime	ore, MD 21201		
S Regis		31. Date filed (Month, Day, Year) 32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Reg. No. 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 6:25 PM Robert L. Wright 2010 Jan. 28, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis Anne Arundel Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year)
April 24,1937 5. Social Security Number 7. Age (In yrs. last birthday)
72 Yrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F 255-54-4629 April Georgia Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Severna Park MD Anne Arundel 1 □Yes 2 No traumatic event, the Medical Examinar must be notified Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 8 River Drive 21146 Funeral 12. Was Decedent Ever in U.S Armed Forces? 1051 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status orces? 2□No 1955 ve 1975 Black, White, etc. 1 Never Married 2 Married Yes 2 Yes, Give White 1 ☐ Yes 2 🛣 No Specify Specify: δ 3 Widowed 4 Divorced Year or Dates: Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) Naval Academy 12 Supervisor of Maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willie Wright Pauline Dorsey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce C. Wright / Wife 8 River Drive Severna Park, MD 21146 permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr Feb. 01 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery Crownsville, MD 2010 Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Functal Service License 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Approximate Interval Between Onset and Death 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 1 Tes 2 No 4 Unknown Completed Æ4b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yeş⁄ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Man of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

law requires that the death certificate be executed attending physician and for use as the burial-trar Box 68760. signed by the a P.O. Records, s certificate has t irector, page 2 s Hospital or Attending Physician; The Division of Vital this After th funeral n 24 hours after death.

The Funeral Director: A pletely filled in by the fune funeral bletely filled in by the funeral bletely filled in by the funeral bletely filled in by the funeral bletely filled in by the funeral bletely filled in by the funeral bletely filled in by the funeral bletely filled in by the funeral bletely filled in death. completely within 2

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Health and Mental em 27 Is marked o should be

illed within 7 I Hygiene.

Maryland 21215-0036

Baltimore,

State

Registrar

Medical

29a. Certifier

(Check only one)

31. Date filed (Month, Day,

29b. Signature and title of certifier

Yea

FEB 02

2 Medical Examiner:

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year,

Name and address of person w of death (Item 23a) (Type, I

400

1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 = For AMEND#18, 20b per Registrar 2/2/2010 AACC	EHState of Mar	yland / Dep	artmen ertificat	t of H e of L	ealth a	and M	lental Hy	giene Reg. No.	2010	01	1365	
th.	900		Decedent's Name (First, Middle, La.		VH -					2. Date of Dea	ath	. Va.,	3. Tim	ne of Death	
	Physicia /Medic		Paul Denis Whe	lan Jr.						Month January	Day 7 30	2010	4:	58 P ^M	
	Examin	_	4a. Facility Name (If not institution, give	e street and number)		4b. City,	Town, or	Location of	of Death			County of Dee	ith		
1			Anne Arundel Med			/) If Under		apoli		0.0		Anne Ar		-10 - 2 - 5 - 2 - 2	
8	Funeral		5. Social Security Number 6. S 217–58–4271	ex 7. Age (XDM 2□F	In yrs. last birthday 57 Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da	y, Year)	C	ountry)	ate or Foreign	
	Director		Usual Residence of Decedent							6/13/1	1952	Ma	rylan		
	how		10a. State 10b. County		Oc. City, Town or L									de City Limits Yes 2 ☐ No	
	Be-f s	cto	Maryland Anne Ar	under	Annar						10- 0'''				
	with the	Dire	10e. Street and Number 909 Wells Avenue			10f. Zip	Code	2140	13	10g. Citizen of What Co			ountry ?		
	72 hours after death with the Maryland 'natural', or Itams 23a or 28e-f show dical Examiner must be natified at	by Funeral Director	11. Marital Status	12. Was Decedent Eve	er in U.S. 13	. Was Dece	dent of H			ecify Yes or No Rican, etc.)		14. Race - American Indian,			
9	or Kar	Fun	1 Never Married 2 Married	Armed Forces?		if Yes, special of Yes		in, Mexicar Specify:	n, Puerto	Hican, etc.)		Black, Whi			
21215-0036	ours a	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	70–74	1 🗆 163	2 X 140	зреспу.			Specify: White				
5-0	"natu	Completed	15. Decedent's E (Specify only highest gra		(Giv	edent's Usu: e kind of wo DO NOT u:	rk done d	during mos	t of work	ing	16b. Ki	nd of Business	s/Industry		
12	within ene.	ошо	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)		es Cle		"/			Fac	stport	Liano	ra	
	e filed within al Hygiene. I other then " vent, the we	Be Co	17. Father's Name (First, Middle, Last,		Baie	SS CIC	T 17	18. Mothe	er's Nam	e (First, Middle,			midao	Lo	
lan	Ald be Alental rked o	To B	Paul Denis Whe	lan Sr.				P	Ada E	Elizabet	ch ₩	lelan	Ritte	er	
Maryland	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Heatth and Mental Hygiene. ortant: If item 27 Is marked other then "natural", or Itams 23a or 28e-f show injury or other treumatic event, the Medical Examinat must be natified at 8.		19a. Informant's Name/Refationship (al Route Numbe			Zip Code)		
	s 1 and 2 of Health item 27 I		Linda Whelan -	Wife	20b. Place of Disp					apolis,		21403 ocation - City or	r Town Sta	to.	
Baltimore,	iges 1 it of H if ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		cemetery, cr	ematory or o	other plac			2010				10	
Ħ	permit. Pages Department of H Important: If ite any injury or of		* 4 □Donation 5 □Other (Special Signature of Funeral Service Lices		Baltimon	ce cre 22. Name ar				2010 hn M. 7		ltimore		omo	
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*	/Medical Examiner		resulting in death)	Due to (or as a					_						
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760,	e ys	cal	(d											
9	that the death certifica ed by the attending ph detached for use as th	Med	IF FEMALE:												
Вох	ath ce	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death 3	□Ectopic p		,				23d. Date of de Month	elivery Day	Year	
0.	the de y the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tir 9□ Unknown	ne or death 5	Other (sp	оөспу)								
Δ.	that the the the the the the the the the th		Part II. Other significant conditions	contributing to death but	not resulting in the	underlying o	ause giv	en in Part I		23e. Did t	obacco u	use contribute	to the cause	e of death?	
Records,	The law requires are has been sign bage 2 should be	ed by								1 🗆 '	Yes 2	□No 3□F	Probably	4. Onknown	
CO	aw require is been si 2 should b	Completed								24a. Was		24b. Were a	autopsy find	lings available	
R	The law ate has page 2 s	E								perfo	rmed?	death?			
Viita	Physicien: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?						e of Deat	h (Check only o	one)				
of \	8 S D	၉	1 ☐ Yes 2 ☑ No	Hospital:				4 🗆 🖂	ursing Ho	ome 5 Resi			ecify)		
Sn C		lon:	27. Manner of Death 1	28a. Date of fnjury (Month, Day	Year) 28b. Time Injury	M	28c. Injur Wor	ya≀ k? Yes 2 🗍	No	28d. Describe	now infu	ry occurred			
Division		Certification:	3 Suicide 6 Could not b	28e. Place of Injury	/ - At home, farm, s					28f. Location (Rural Route	Number,	
<u>S</u>	afor / s after if Dira	Serti	4 Homicide	building, etc.	(Specify)					City or To	wn, State	9)			
	To the Hospitel or At within 24 hours after or To the Funerel Dirac completely filled in by		29a. Certifier 1 Certifying Pl	nysicien: To the best of miner: On the basis of e	my knowledge, de	ath occurred	at the tin	ne, date ar	nd place,	and due to the	cause(s)	and manner a	as stated.	use(s)	
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\	To the Within To the	~	29b. Signature and title of certifier			29		38-3	03		1	/ /	0/0	/	
	HAN		20 Name and address of access to	completed cause of dea	ith (Item 23a) /Tim	e Print)	レ	000	<u> </u>			20/2	70		
2-	+ Wet	+	30. Name and address of person who	WTSCHIR			ME	OFCA	-C PK	- int	ANN	APOLTS	100	2140	
	Sta	ite	31. Date fifed (Month, Day, Year)	010 32. Pegistrar		back									

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Zhi Qiang Zhang 12:15 A.M 2010 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Derwood Casey House - Montgomery Hospice 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye Hours Country) China 1 X M 2 □ 88 Director 219-25-5688 192 Sept Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 72 hours after death with the Maryland 10c. City. Town or Location Director Germantown 1 Yes 2 No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5 Madrigal Court 20876 China Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Asian 1 ☐ Yes 2 K No Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve Yuzhen Han Shenfa Zhang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lingin Shen / Spouse 5 Madrigal Court, Germantown, MD 20876 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 30, Alexendria 4 Donation 5 Other (Specify) 22. Name and Address of Facility
DeVol Funeral Home, 10 East Deer Park Drive,
Gaithersburg, MD 20877

Approximate 21. Signature of Funeral Jer ice Licensee Part / Whiter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Heart Failure Physician Months disease or condition Medical resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of Renal Failure 24a, Was an Encephalopathy autopsy page performed? Yes 2 X No death? Hospital or Attending Physician: The 2 🗆 No 1 🗌 Yes Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 🗓 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) 욘 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and the 29d. Date signed (Month, Day, Year)
January 24, 2010

Registrar DHMH 17 Rev 7/2009

State

ss of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signaters

Joseph Puthumana, M.D.

31. Date filed (Month, Day, Year)

D47123

201 E. University Parkway, Baltimore, MD 21218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 PER PHY G901 3/11/2010 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Enrique Alonso Zepeda Month Physician/ Year 3:30 M cun 2010 Medical 4a. Facility Name (if hot institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours El^cSälvador Ju**TVT2**°,1[°]924 212-47-0351 85 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Maryland Prince George's College Park 1 X Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ö Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I Funeral 20740 El Salvador 4711 Mangum Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces

1 ☐ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: White 1 X Yes 2 □ No Spec Salvadorian If Yes, Give 3 🗌 Widowed 4 🗌 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Press Operator Newspaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Ofelia (unk) ဂ္ Armengol Roca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) German Zepeda -son 4405 Apex Lane Beltsville, Maryland 20705 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Metropolitan Crematory 1/24/2010 Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signafure of Funeral Service Licensee Bonald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, PA Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami ZSCHEMIC To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the 74 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Yes 2 🗆 No 9 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes 25. Was case eferred to medical examinar?
1 ✓ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) Certificate: To 1 ☐ Inpatient 2 Z ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Don Michael Coleman, II, M.D. WAH 7600 Carroll Avenue Takoma Park, Maryland 20912 31. Date filed (Month, Day, Year)

JAN 28 2010 Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04368 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 03: 16AM **EDITH** ZOTTL S. 01 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Feb. 8,1921 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Hours Min. Months Days 88 251-28-5773 Georgia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Department of Health and Mental Hygiene. Important; or Items 23a or 28a-f show important; If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Evariant count to institute an any Injury or other traumatic event, the Medical Evariant count to institute an any Injury or other traumatic event, the Medical Evariant count to institute and one of the property of the pr Maryland Bethesda Montgomery 1 ☐ Yes 2 No Director the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20817 United States 9 Park Overlook Court death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give WWII Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 2 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nellie Price Sidney Theodore Simmons Jr. 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3431 Fawn Hill Road, Matthews NC Karl A. Zottl (Son) Date 28, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Alexandria, VA Metropolitan Crem. 2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service License 10 East Deer Park Dr. Gaithersburg, MD 20877 wites 23a. Part 1. Enter the disease, or complication hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cadiac Arrest /Medical Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Severe Shock Due to (or as a consequence of) Physician/Medical Sepsis 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 📉 No P.O. 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hyperkalemia autopsy performe 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signa lun-24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Nourani Zemur M.D. Old Georgetown Road Bethesda, MD 20814 Sima 31. Date filed (Month, Day, Year)

JAN 2 9 2010 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1 , Physician/ EERUARY John L. Allen ¥201 27:11FM Medical 4a. Facility Name (if not institution, give street and number)
Saint Joseph Medical 4c.County of Death Baltimore **Examiner** 4b. City, Town, or Location of Death Center 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** June 5, 1919 1 🕅 M 2 🗆 F Months Days Hours Min. Director 147-18-5067 90 Connecticut Usual Residence of Decedent or 28a-f shov 10b. County 10c. City. Town or Location with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Baltimroe Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 12230 Roundwood 21093 USA Page 1 and 2 should be filed within 72 hours after death a ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner m. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: white 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unit manager insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John Lawrence Marietta Bombard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Hanford/daughter Trebor Court Lutherville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or 4 □ Donation 5 🖾 Other (Specify) in state Signature of Funeral Sovice Licensee Ronal of Sylvadie State Anatomy Board 655 W. Baltimore Street Director will MD 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ SEPTIC SHOCK Medical resulting in death Due to (or as a consequence of) Examiner RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed METASTATIC PROSTATE CANCER Due to (or as a consequence of): Physician/Medical CORONARY ARTERY DISEASE Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 2 No Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 **X** No Hospital Other 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending iniury work? 2 No nours after death neral Director. A filled in by the f M Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier 1 Certifying Physician To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Medical Examiner: 0 3 Certifying Nurse Practioner: To the best of my k only one) owledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ertifier 29c. License number D42736 30. Name and address of person who completed caus (Item 23a) (Type, Print) MAMYA FATHI OSLER DRIVE TOWSON, MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's State FEB 18 2010

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ 0347 Februar 3010 00150 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AIR UPPER CHESAPEAKE HARFORD HOSPI +AI If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Carolina 1 M 2 K Hours 242-50-4505 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Belaic 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21009 12. Was Decedent Ever in U.S. Armed Forces?.
1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Maryland 21215-0036 1 Yes 2 No Specify: and Mental Hygiene. is marked other than "natural", If Yes, Give Year or Dates Specify: 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2100 9 19a. Informant's Name/Relationship (Type, Print) Department of Health are Important: If item 27 is any injury or other trau BELAIR, MARYLAND 110 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State Woodlawn 4 Donation 5 Other (Specify) O3 30 13010 Dernox C Jones F.H. 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ FROKE Da disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner HELTE 0 (4RD)A Secure tially list or in little as Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) HOOMIC 4 Cause (Disease or linjury ACVTE that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical SINDO The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate Division of Vital Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) B B examiner? Hospital 2 No Certificate: To Inpatient 2 ER/Outpatient 3 DOA 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne eath funeral 28b. Time of 28d. Describe how injury occurred 28c. Injury at injury work? 1 ☐ Yes 2 ☐ No 5 Pending Natural Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Purse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certi-66342 Paten m.O. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kapilkumar HES. 500 31. Date filed (Month, Day, Year) 32. Regist State 2010 Registrar

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #31 per DVR g900 2/18/10 TT State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 02 Day 10 Physician/ Year BUCKOWITZ 0917 MELVIN, DAVID, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CENTER MEDICAL Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign MARMLAND 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Months Hours (Month, Day, Year, 220-30-4010 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amp injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No OWINGS MILLS BALTIMORE MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 4601 WATERFALL COURT, APT. T-1 21117 12. Was Decedent Ever in U.S. Aymed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify: 14. Race - American Indian, 11. Marital Status þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 3 Widowed 4 Divorced Specify: WHITE Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) WRITING **AUTHOR** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 ALBERT BUCKOWITZ FRIEDA JACK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 GLENCLIFFE CIRCLE, PIKESVILLE, MD 21208 SANDRA BUKOWITZ GORDON/COUSIN 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State ARLINGTON CHIZUK lace) 2/16/2010 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service License wttVM 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Asphykia, mucus Medical Due to (or as a consequence of): Examiner 30 years Multiple Scierosis Sequentially list conditions, Examine Duty to for as a nonsequence of it any, leading to immedicause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or linjury and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Day Year 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signe should be c 2 № No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 ✓ No 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) 8 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital; 1 Yes 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Fractioner To the best of my knowledge. Meth one ed at the firme, data and stars, and due to the collected and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NPI 1578798310 02-10-2010 MD 19694 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Greene 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2010 Registrar

E

			Please T	ype or Print in Blac AMEND TTEM#22per State of Maryland / L	k Indelible In	k. Ensure A	All Copies	Are Legible	
		-	State Registrar		Certificate of L			g. No. 2010	0 4 3 7 2
	Physicia Medic		1. Decedint's Name (First, Middle, Last)	brooks			2. Date of Death	5,2010	3. Time of Death
	Examin			eventist Hospit	al Rocki	r Location of Death		4c County of Dea	mery
ı	Funeral Director		410 10 3260	Walter 70	Months Days	Hours Min.	8. Date of Birth	1927	rthplace (State or Foreign ountry) SC
	f show	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town				-	10d. Inside City Limits
	the Mary or 28a- e notifie	Director	10e. Street and Number	Bal	fi more		10	Og. Citizen of What C	1 Yes 2 No
	ns 23a must b	Funeral	2912 Forest Gle	en Koad 2. Was Decedent Ever in U.S.		216	ecify Ves or No-	USA	orion Indian
5-0036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ě	11. Marital Status 1 □ Never Marrled 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🕦 No		ecily tes of No- Rican, etc.)	14. Race - Am Black, Whi	
21215-(ithin 72 hou ene. • than "nati • the Medica	Completed	15. Decedent's Educ (Specify only highest grade Elementary Seconday (0-12)	cation 16a. completed) College (1-4 or 5+)	Decedent's Usual Occup (Give kind of work done of life, DO (101) use retired)	during most of wor)	king	16b. Kind of Business	1 .
Maryland 2	I be filed within fental Hygiene. rked other tha tic event, the I	To Be	17. Father's Name (First, Middle Last)	ley	71000	1	ne (First, Middle, Ma		1
Mary	and 2 should be file Health and Mental I em 27 is marked o ther traumatic eve		Informant's Name/Relationship (Type		Mailing Address (Street	and Number or Rul	Balto:		(ip Code)
Baltimore,	Page 1 and nent of Heal ant: If item : ury or other		20a. Method of Disposition 1	20b. Place of	Disposition (Name of		Date 2	oc. Location - City of	1 -
Balti	permit. Page 1 Department of Important: If is any injury or c		21. Signature of Funeral Service Licensed	100 40	22 Name and Ardre	ess of acilit	eene Fu	ral 5 8728 Liberty	Rd. Balto. Md
	Physician/	. (4	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	rations that caused the death, Do n cause on each line.		ng, such as cardiac			Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a consequence of	al Inf	arctio	\cap		40 Min
8	e executed cian and ourial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c.	Due to (or is a consequence of Diabetes	Mellit	us			Years
90 09	cate be exe physician a s the burial-		resulting in death) Last	Due to (or as a consequence of	η: 				
Box 68760	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death certificate be 34 hours after death certificate has been signed by the attending physic attend in by the funeral director, page 2 should be detached for use as the but the 35 hours are as the but at the 35 hours are as the 55 hours are 35 hou	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	су		23d. Date of d Month	elivery Day Year
, P.O.	ss that th igned by be detac		Part II. Other significant conditions cont	ributing to death but not resulting in	n the underlying cause gi	iven in Part I.			to the cause of death?
Records,	w requires the speed signer is should be a	Completed by					24a, Was an	24b. Were a	utopsy findings available
Rec	ician: The law certificate has bector, page 2 s						autopsy perform 1 Yes 2	ned? death?	es 2 No
of Vital	ysician: his certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital:	Toth	lace of Death (Chec ner: 4 Nursing H		nce 6 Other (Spe	ecify)
on of	nding Ph ath. : After thi e funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. T	njury worl		28d. Describe hov	v injury occurred	
Division	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Af completed filled in by the fu	I Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
	the Hospil hin 24 hour the Funera	Medical	(Check 2 Medical Examine	ian: To the best of my knowledge, or: On the basis of examination and/o Practioner: To the best of my knowl	r investigation, in my opini	ion, death occurred	at the time, date and	place, and due to the	e cause(s) and manner stated.
	To the vithin comp		29b. Signature and title of certifier	IMI I	29c. Licens MO 6	se number 8 Y § S	29	Od. Date signed (Mon	th, Day, Year)
	7		30. Name and address of person who con	npleted cause of death (Item 23a) (Type, Print) 9901 MD ROCK	medie cville	al Cen	ter Driv	و
	Stat	е	31. Date filed (Month, Day, Year)	32. Registrar's Signature	ladel.		,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State o	f Marylan		rtment of H		∕lental Hygi	iene	110	01.273
			1 - State Registrar			Cer	tificate of L	Death		9.110	110	04373
	Physici	an	1. Decedent's Name (First, Middle, I	,	O EIG	. 1			2. Date of Death Month January		Year	3. Time of Death
	/Media	cal	01/11/000		CFIEL	- <i>D</i>	45 02 7	Leading of Death	January			3:00 PM M
	Examin	ner	4a. Facility Name (If not institution, g					Location of Death		4c. County		I
	Funeral		St. Thomas Mor 5. Social Security Number 6.		7. Age (In yrs. I	last birthday)	Hyatts If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Princ	9. Birthp	lace (State or Foreign
	Director		238-46-6251	1 M 2□ F	76	Yrs.	Months Days	Hours Min.	Sept 2,	1933	Nort	h Carolina
	pr ,	1	Usual Residence of Decedent		1							
	arytai show	<u>_</u>	10a. State 10b. County			y, Town or Lo					1	0d. Inside City Limits 1 □Yes 2 ☑ No
	he M.	Director		George'	s Hy	attsvi				0111	111111111111111111111111111111111111111	
	with t	ក្ដ	10e. Street and Number				10f. Zip Code 2078	22	10	og. Citizen of USA	What Coun	try?
	be filed within 72 hours after death with the Maryland the Wignen. Independent than "natural", or items 23a or 28a-f show event, If a Modral Examination must be notified at	by Funeral	4922 LaSalle Ro		edent Ever in U.S	S 13 V			necify Ves or No.		ce - Americ	an Indian
_	fter d	Ξ	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Fo	rces?		Vas Decedent of Hi Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Bla	ck, White, e	etc.
ຼັ	al",o		3 X Widowed 4 ☐ Divorced	If Yes, Giv Year or D	ve	1	□Yes 2⊠No	Specify:		Specit	_{y:} bla	ick
<u>-</u>	72 ho	Completed	15. Decedent's (Specify only highest of	Education		16a. Deced	lent's Usual Occupa	ation	ing 1	6b. Kind of B	usiness/Ind	dustry
21215-003	ithin ne.	Jg .	Elementary/Secondary (0-12)	College (1		life. L	kind of work done o OO NOT use retired)	I .	constr		an.
7	led w lygier her th		5	()		mechanic	40.44.4.4.4.				·11
Maryland	d d d	Be	17. Father's Name (First, Middle, La Richard Barfie)					18. Mother's Nam	e (First, Middle, M Le Gorhan		ne)	
Š	should I and Men s marke umatic	2	19a. Informant's Name/Relationship			10b Mailin	g Address (Street a	and Number or Pur	rol Pauto Number	City or Town	State Zin	Cada
Ž	nd 2 sho Ilth and 27 Is ma r trauma		Deborah Barfiel		er	1	Mountair			-		*
คั	es 1 and 2 of Health a fitem 27 is rother tra		20a. Method of Disposition	.u/ uuugiit			sition (Name of natory or other place			20c. Location		
e E	Pages nent of int: if its iry or o		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 💢 Other (Spec		State	ететету, сгеп	latory or other place	e) ;				
aitimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 Is marke any injury or other traumatic once.	1 6	21. Signature of Funeral ervice Lic	ensee		22	. Name and Addres	ss of Facility	.1 6EE 11	Pol+i	m 14 O O	Ctroot
מ	B II De	8	Konald S.	Was all	rector		altimore			ватт	mroe	Street
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on	mplications that c	aused the death				or respiratory arre	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	1	Monor	Inte	cardin	resolar	desen	14		Onset and Death
	/Medical Examiner		resulting in death)	Due to ((or as a consequ				CLIOUP			
	Ladillilei	<u>_</u>	Sequentially list conditions,	b	NORTH CO.							
	ted nsit	Examine	if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(vi as a consequ	ience oi).						
	execu n and al-tra	xar	that initiated events resulting in death) Last	c	(or as a consequ	uence of):						
0/0	cate be executed physician and the burial-transit	dical		d								
00	tificat ng ph) as the	ledi		u								
Ž D D	th cer endin	J.	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		Ectopic pregnancy	,		23d. Da	ate of delive	,
	e deat	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of de		Other (specify)	/		M	onth	Day Year
7. O	requires that the death certifi seen signed by the attending nould be detached for use as	Physician/Me	9 Unknown			Main m. I = 47	deal le	en in De d I	00+ 0111		della de 4 - 11	an annua of dorses
vital Records,	rres th signer		Part II. Other significant conditions	contributing to de	eath but not resu	ating in the un	derlying cause give	en in Part I.				ne cause of death?
5	requi	eted	- UWINIS		-							
ב ב	The law ate has b	Completed by							24a. Was ar autopsy perform	24b.	Were auto prior to con death?	psy findings available mpletion of cause of
5	i: Th ficate r, pag								1 Tyes 2	No	1 ☐ Yes	2 □No
	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			t 3 DOA Othe	25"	h (Check only one			WYY
5	r this er this	F. I	1 Yes 2 No 27. Manner of Death	28a. Date	Inpatient 2	28b. Time of	t 3 ∐ DOA 28c. Injury Work	THUISING NO	ome 5 Reside	· · · · · · · · · · · · · · · · · · ·		y)
200	th. : Afte	tio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigati		th, Day, Year)	Injury		? Yes 2 □ No		,,		
<u> </u>	Affer ar dea ector	ifica	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place	of Injury - At ho	me, farm, stre	et, factory, office		28f. Location (Str	reet and Num	ber or Rura	I Route Number,
5	rs after or all Dir ed in	Certification: To	4 🗆 Hornicide	Duildii	ng, etc. <i>(Specif</i>)	1			City or Town			
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. Within 24 hoursal Director: After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as		(Check only 2 Medical Ex	Physician: To the aminer: On the h	best of my know	wledge, death	occurred at the ting	ne, date and place,	and due to the carred at the time. da	ause(s) and nate and place	nanner as s	tated.
	the F hin 24 the F nplete	Medical	one)	and mani	ner stated.							
	6	2	29b. Signature and title or codifier	20		-	29c. License	368/	29	od. Date signe	/	
	ĺ			7.=	-			7		1/80	1201	U
			30. Name and address of person wh Ajit Kurup	ST. Thon			,	tsville M	ſD	' /		
	Sta	to	31. Date filed (Month, Day, Year)					COATTIE L	ω			
	Registr		FEB 18 201	1 Denn	legistrar's Signat	Again						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1350 201 ICHANAN Februna Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MEDICAL -TIMORI OF MARYLAND Sex 1 ፟M 2 ☐ F If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday **Funeral** Days Months Hours Min. 01–13–1957 Pennsylvania **Director** 190-48-9018 Usual Residence of Decedent i Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 ื No MD Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funera 1207 Brietwert Avenue 21113 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married ò Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Stone Mason Brett Rugo Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic Avontants 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Buchanan JoAnn Warmus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen J. Buchanan / Wife 1207 Brietwert Avenue Odenton, Maryland 21113 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
HILLCrest
emorial Gardens 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Annapolis, Maryland 02-16-2010 Donaldson Funeral Home & Crematory, P.A. 21. Signature of Funeral Service Licensee Annapolis Road Odenton 23a Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician disease or condition resulting in death) NTRAABDOMINAL ABSCESSES Medical Due to (or as a consequence of) **Examiner** a months Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) the. Unknown 9 Unknown P.O. ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed certificate 2 \square No 1 Yes Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Minpatient 2 🗆 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending work 1 Tes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

015. GREENE ST

BALTIMORE, MD 81201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EPHI

EKU, HD

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Der 1- State Amend Item 4a per dr., g900	partment of Health and I 2/18/2010 dhb ertificate of Death	Mental Hygie Reg.	ne 2010 04375
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year
	Physici /Medic		THOMAS SERNARUI	HE	FFB. 3, 0	2010 10:50AM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death
П			108 51H STREET Avenue	CILEN BUK	NIE	Anne Arundel
	Funeral Director		5. Śocial Security Number 214-58-5702 6. Sex 1 7. Age (In yrs. last birthda, 60 Yrs.	/) If Under 1 Year	8. Date of Birth (Month, Day, Ye 07/11/19	9. Birthplace (State or Foreign Country) Maryland
	p		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	ocation		10d. Inside City Limits
	anylai shov	_				1X Yes 2 □ No
	8a-f	Director	MD Anne Arundel Glen B		100	Citizen of What Country?
	with t	급	10e. Street and Number	10f. Zip Code	109.	U.S.A.
	s 23	sral	108 5th Avenue 11 Marrital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (S	necify Yes or No-	14. Race - American Indian,
336	filed within 72 hours after death with the Maryland Hygiene. thar than "natural", or Itams 23a or 28a-f show thar than "hadical Exemplian" and be muffied at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Órigin? (S If Yes, specify Cuban, Mexican, Puerl 1 Yes 2X No Specify:	o Rican, etc.)	Black, White, etc. Specify: White
9-0	2 hor	Completed by	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Git	edent's Usual Occupation re kind of work done during most of wo	ting 16b	. Kind of Business/Industry
215	thin 7 8.	ed c	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	A"'y	
21	od wil	Con		intenence Planner		Manufacturing
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Mai	den Sumame)
<u>yla</u>	S should be filed withir and Mental Hygiene. Is marked othar than aumatic event, Its M.	은	John Bernarding		a Jansen	
, Maryland 21215-0036	r 2 light		Donale Bernarding/Wife 1	iling Address (Street and Number or Ri 08 5th Ave., Glen	Burnie, M	D 21061
Baltimore,	0 0	A CANTON		ematory or other place)		c. Location - City or Town, State nover, Maryland
Baltii	permit. Pag Department Important: I any injury c			22. Name and Address of Facility A		ation Services
	_		23a. Part1. Enter the disease, or complications that caused the death. Do not e	nter the mode of dying, such as cardia	or respiratory arrest,	Hanover, MD 21076
			shock, or heart failure. List only one cause on each line.			Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of):	NON SMALL CE	u LUN	6 CANCER 1 YEARL
	Examiner		Due to (or as a consequence of).			
		ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
Ć,	ate be executed hysician and the burial-transit	Еха	resulting in death) Last Due to (or as a consequence of):			
8760	ysicia ysicia	dical	d			
9	tificate ig phys as the	edi				
O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me		B Ectopic pregnancy Country Other (specify)		23d. Date of delivery Month Day Year
<u>α</u>	that the de led by the a detached i		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
Records,	uires tha n signed l	d by			1 Yes	2 No 3 Probably 4 Unknown
202	w requir been si should	Completed			24a. Was an	24b. Were autopsy findings available
Re	he fav e has ige 2 :	m d			autopsy performed	
a		CC	25. Was case referred to medical	OC Place of Do		No 1 ☐ Yes 2 ☐ No
Vital	Physician: The l this certificate har ral director, page	00.	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	Other	ath <i>(Check only one)</i> Home 5 X Residenc	e 6 Other (Specify)
of	Phys r this rral dii	7. To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how	
on	ding I th. After funer	tlor	1 XNatural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 □ Yes 2 □ No		
Division	or Attending after death. Diractor: After in by the fune	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,	street, factory, office		at and Number or Rural Route Number,
Ö	al or A after I Dirac d in by	Certification;	4 Homicide determined building, etc. (Specify)		City or Town, S	SIATE)
	To the Hospital or Attending Phwithin 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de a control of the desired form of the de	ath occurred at the time, date and placinvestigation, in my opinion, death occ	e, and due to the caus urred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To tha complet	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	->-0		reviele Ms	D16354	2	13/2010
			30. Name and address of person who completed cause of death (Item 23a) (Type EW COLE STAGNES 900 CA)	e, Print) AVF RAI	TIMORE	MD 21229
	Sta Regist		31. Date filed (Month, Day, Year) 37 Registrar's Signature	are		
	negisti	101	FEB 18 2010 Cerous B. A.			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 28, 2010 10:00 A M Physician/ Chew Bernard Briscal1 Medical 4c. County of Death 4b, City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Rockville Casey House 8. Date of Birth
(Month, Day, Year)
6. 1918 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex **Funeral** 1 ★ M 2 □ F Davs Hours Min Illinois 91 Yrs. 577-09-7176 **Director** Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10c. City. Town or Location Director 1 Yes 2 No Potomac MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 20854 8912 Falls Chapel Way 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2XXNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married by 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Technology College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Aerospace Mechanical Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle, Last) မှ Chew Pauline Arthur Percival 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8912 Falls Chapel Way, Potomac, MD Eleanor L. Chew / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State Beltsville, MD Chesapeake Crematory:1/30/2010 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility app Funeral and Cremation Services 33 Gist Ave., Silver Spring, MD Signature of Funeral Sorvice 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Anoxic Encephalopathy Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 25 days Hip Fracture Sequentially list conditions, if any least section of the cause. Enter Underlying Cause (Disease or linjury Examiner Due to lor as a consequence of): Coronary Artery Disease anding physician and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year in the past 12 months? Pregnant at time of death 1 Yes 2 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy page 2 death? Yes 2 No 1 ☐ Yes 2 ☐ No certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be 4 Nursing Home 5 Residence 6 Nother (Specify) 1PU examiner? 1 X Yes 2 ☐ No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: work ☐ Natural 5 Pending Fall at home 1 Yes 2 No 01/03/10 a.M X Accident Investigation 24 hours after death Funeral Director: A 28f. Location (Street and Number of Burat Poute Number City or Town, State) 8912 Falls Chapel 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 4 Homicide filled in by determined Way, Rockville, MD 20854 Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. сотріете Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier february 16, 2010 J. Kouatchou D63748

DHMH 17 Rev 7/2009

State Registrar Jocelyne Kouatchou, M.D. 6001 Muncaster Mill Rd. Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Bettie Irene (hesnu Feb 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Howard County General Hospital Howard Columbia If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months 1 □ M 2 🛛 F 1926 83 June 1, Director 216-20**-**8751 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it a Madical Evarcity or other traumatic event, it a Madical Evarcity or other traumatic event, it a Madical Evarcity or other traumatic 10a. State 10b. County 10c. City, Town or Location Funeral Director MD Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9012 Watchlight Court 21045 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: white Specify. Be Completed by 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 telephone operator communications 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Charles Wheelen Blanch Irene Alexander ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Chesnut/daughter 9012 Watchlight Court Columbia, MD 21045 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street ade, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): the burial-tran Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes outcome of pregnancy

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, cate has been sign page 2 should be funeral director.

Be Completed by Medical Certification: To within 24 hours after death To the Funeral Director: filled in by completely

23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☑No 9 □ Unknown	1	Month Day Year				
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Tinknown				
· Acute renal of · Pulmonary Em	bolys	24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 1 □ Yes 2 ☑ No 1 □ Yes 2 ☑ No				
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	25. Was case referred to medical examiner?					
27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Ďay, Year) Injury Work? M 1 □ Yes 2 □ No	Bd. Describe how injury occurred				
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Bf. Location (Street and Number or Rural Route Number, City or Town, State)				
	ysician: To the best of my knowledge, death occurred at the time, date and place, a niner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.					

29c. License number

D6066 515

203

9. Birthplace (State or Foreign Country) Maryland

10d. Inside City Limits

Approximate Interval Between Onset and Death

29d. Date signed (Month, Day, Year)

Fes

01

2010

1 ☐ Yes 2√☐ No

State Registrar

Vishi 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1

29b. Signature and title of certifier

M.D 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 4a per MD 9900 2/18/10 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February Day 2010 **Physician** 4:35 A M DOROTHY COHNEN /Medical 4b. City, Town, or Location of Death 4c. County of Death give street and number) Examiner N/A BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 7/11/1910 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F 214-40-5755 99 MD Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene.

m 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director N/A MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 830 W. 40TH STREET, #1129 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Be Completed by 3 Widowed 4 □ Divorced WHITE 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) SOCIAL WORKER SOCIAL WORK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HENRY **JANDORF** RENA ပ္ STRAUSS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) NEAL MYERS/SON 5520 ETTA COURT, COLUMBIA, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 □ Removal from State BALTO. HEBREW CEM. 2/18/2010 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee **Physician** /Medical

Examiner

Division or Vital Records, P.O. Box 68760,

!	Coliella-	same/	8900 F	REISTERSTOWN	ROAD, PIKE	SVILLE,	MD 21208					
	23a. Part1. Enter the disease or emp	one cause on each line.	o not enter the mo	ode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death					
10.0	immediate Cause (Final disease or condition	End-stage of	emeasis	J.			Leave .					
ı	resulting in death)	Due to (or as a consequence	e of):									
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as a consequence	e of):	<u> </u>								
dical Exa	that initiated events resulting in death) Last	Due to (or as a consequence	e of):									
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 5 ☐ Other (specify) ☐ Month 23d. Date of de Month											
þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute 1 Yes 2 Wo 3											
Completed					24a. Was an autopsy performed 1 Yes 2 1	? death?	autopsy findings available completion of cause of s 2 \(\square\) No					
Be (25. Was case referred to medical examiner?				ath (Check only one)							
2	1 Yes 2 No		Outpatient 3 □ □	OOA Other: 4 Nursing I	Home 5 ☐ Residence	6 □Other (Sp	ecify)					
	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation											
Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, building, etc. (Specify)	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or City or Town, State)									
dical (ysician: To the best of my knowled niner: On the basis of examination a and manner stated.										

Registrar DHMH 17 Rev 1/2001

State

within 24 hours at To the Funeral D

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JI BABEZLE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARGREGIR,

W

013657

STREET, BALTIOTORE, ORD 21211

29d. Date signed (Month, Day, Year)

February 15,2010

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend item 12.18 per fn 8900 2-23-10 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar 04379 Certificate of Death Rea. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20ปี๊ก 11:45p M Phillip U. Daniels February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 915 Punjab Circle Essex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 😿 M 2 🗆 F Months Days Hours Min. Aug. 27, 92 Director Maryland 215-24-1030 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

Item 27 is marked other than "natural", or items 23a or 28a-f sho of them 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2 X No Baltimore Maryland Essex 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21221 915 Punjab Circle United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Armed Forces?

1 X Yes 2 X No WWII Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Furniture Finisher State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Edward Daniels unknown Carrie Ann Daniels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 915 Punjab Circle, Essex, Maryland 21221 Yvonne Daniels/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or otl cemetery, crematory or other place) February 16 1 ☐ Burial 2 😿 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Metro Crematory, Inc. 2010 22. Name and Address of Facilit Cremation Society of Maryland, Inc. Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. End Stage Parkinson Disease vears Medical resulting in death) Due to (or as a consequence of) Examiner Dementia with failure to thrive vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence or, Hypertension with ischemic heart disease and Due to (or as a consequence of) the burial attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Dysphagia Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Hydronephrosis, immobility syndrome, prostate 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed been 24b. Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No hypertrophy, gallstones, osteoarthritis 24a Was an certificate has page 2 performed 25. Was case referred to medical director, 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 🕱 No ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Manner of Death funeral 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending other Hosuital or Attendir ithin 24 hours after death. othe Funeral Director: At 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. completed filled in by determined City or Town, State) Medical 29a. Certifie 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) within To the 29b. Signatur ertifier 29c. License number 29d. Date signed (Month, Day, Year) D54749 February 16, 2010 30. Name and address of person who completed cause of th (Item 23a) (Type, Print) V Allen Reilly, M.D. 4 East Rolling Cross Road, Baltimore, Maryland 21228

DHMH 17 Bev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Amend #30 Type or Print in Black/Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 04380 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician DICKMAN MORRIS 17:12 PM 2010 02 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY GENERAL HOSPITAL MONTGOMERY DLNEY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours 88 Yrs. 213-01-8477 05/19/1921 **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show Director 1 ☐ Yes 2X No MD MONTGOMERY SILVER SPRING 10e. Street and Number 10g. Citizen of What Country? filed within 72 hours after death with 2904 NORTH LEISURE WORLD BLVD., #517 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 Mayes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 💢 Married 2 No Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: WHITE Specify. Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygienn Important: If Item 27 is marked other that amy injury or other traumatic event, I'm once. BUSINESS OWNER HOME IMPROVEMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MEYER DICKMAN SARAH LEVIN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 EVELYN DICKMAN / WIFE 2904 N. LEISURE WORLD BLVD.,#517, SILVER SPRING, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ⚠ Burial 2 ☐ Cremation 3 ☐ Removal from State BNAI ISRAEL CONG. 2/18/2010 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CERVICAL SPINE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 3 HOURS Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed Due to (or as a consequence of): burial-1 Division of Vital Records, P.O. Box 68760, Physician/Medical as attending IF FEMALE: for use 23c. If yes, outcome of pre-mancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Physician: The performed certificate 1 ☐ Yes 2 🗷 No 1 □ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 es 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending Injury 3:00 PM 1 ☐ Yes 2 🗷 No FALL 2 Ccident investigation 02,16,2010 within 24 hours after deat To the Funeral Director: filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 2904 NORTHLEISURE WORLDBLY HOME 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 02,16,2010 D0060319

State Registrar

DHMH 17 Rev 1/2001



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Physician/ 4:09 AM en 2010 Medical (if not institution, give street and number) 4b. City Town, or Location of Death **Examiner** hrist lowson more t08 If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign Country) last birthday Funeral QMop Q Day, 1927-Months Days Hours 1 M 2 DF MD Director 4.09 or 28a-f shov 10b. County 10a. State City. Town or Location 10d, Inside City Limits death with the Maryland Examiner must be notified at Director Himore 1 🗆 Yes 2 🐪 No 10f Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a a1117 IJSA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc Completed by 1 Never Married 2 Married be filed within 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation
(Give kinded work done during most of working
life, DNNOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than College (1-4 or 5+) lanage 170n Be Maryland မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic onk e. ormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num! Baltimore, Place of Disposition (Name of ormetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ east Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last as the burial-transi attending physician and Due to (or as a consequence of): Physician/Medical Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death been signed by the should be detached Unknown g Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗫 3 Probably 4 Unknown To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been six completed filled in by the funeral director, page 2 should to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 KNO Hospital Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 A other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 1 Deertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (Month, Day, Year) State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

		1 - For Amend Items 8, Registrar	tate of Maryla 9 per sa	3913,03	ertificate of	lealth and M Death	lental Hyc		0 04382				
Physicia /Medic		1. Decedent's Name (First, Middle, Last)	Dobere	~			Month Month	Day 3 20	3. Time of Death				
Examin		4a. Facility Name (If not institution, give stre	et and number)	auder-	4b. City, Town, or Baltun	Location of Death		Be / hiller	eath Cty				
Funeral Director		5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday	1	If Under 24 Hrs.	8. Date of Birtl (Month, Day May 22,	v. Year)	Birthplace (State or Foreign Country)				
/land		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits				
8a-fsh	Director	MD		Balt	imore				1√2 Yes 2 No				
h with th		10e. Street and Number 4005 Hamilton Aven	ue		10f. Zip Code	1206		10g. Citizen of What USA	Country?				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Marical Everifies must be notified at once.	by Funeral	1 ☐ Never Married 2 M Married	Was Decedent Ever in Armed Forces? 1 ∐Yes 2 MXNo If Yes, Give Year or Dates:	U.S. 13	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Spo an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify: V	-				
72 hou	eted	15. Decedent's Education (Specify only highest grade co	on empleted)	16a. Dec	edent's Usual Occup e kind of work done o DO NOT use retired	ation during most of worki	ing	16b. Kind of Busine	ess/Industry				
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d be filed ental Hyg red othe c event,	To Be (17. Father's Name (First, Middle, Last) George William Dobe	erer	<u>'</u>		18. Mother's Name		Maiden Surname) Vilkinson	_				
nd 2 should alth and Me 27 is mark		19a. Informant's Name/Relationship (Type. Print) Elizabeth Doberer/spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z 4005 Hamilton Avenue Baltimore, MD 2120											
Pages 1 ar ment of Hea ant: If item ury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, S											
permit. Departs Imports any Inj		21. Signature of Funeral Service Licensee Ronald S. Way	de Direct	or		tomy Boar		. Baltimo	re Street				
Physician /Medical Examiner		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Constitution of the condition of the condition of the conditions, Sequentially list conditions,											
icate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): d.											
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the t	Physician/Medi	in the past 12 months?	If yes, outcome of pred 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	☐ Ectopic pregnanc	у		23d. Date of Month	delivery Day Year				
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v requii been s should	eted	encostive how	filme	100 th	in Sout	255	24a. Was a		Probably 4 1 Unknown autopsy findings available				
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Hospital c 24 hours af Funeral Di stely filled in	Medical Cer	29a. Certifier (Check only one)	an: To the best of my	knowledge, dea									
To the within To the Comple	Mec	29b. Signature and title of certifier Liser Bull 4	/ M		29c. Licens	se number		29d. Date signed (M	lonth, Day, Year)				
		30. Name and address of person who comp	leted cause of death (I	Item 23a) (Type	S BYVILL	w Cirde	30,1hi	ive MD	21224				
Sta	te	31. Date file Mah, Pag Yang	32. Registrar's S			/	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Francis Horace Dyson Month Year **Physician** February 06 ,2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner timore Hanes 8. Date of Birth October 20,1930 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Yea If Under Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 □ F 79 212-26-2207 Yrs MD Director Usual Residence of Decedent 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the More at a miner must be notified at 1 □Yes 2K No Director MD Baltimore Arbutus 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1132 Gloria 21227 USA Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. illed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify Specify: white \$ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 in and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Pipe Fitter Bethlehem Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Dyson Janie Thompson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any injury or other traur 1132 Gloria Ave. Arbutus MD 21227 Dolores F. Dyson-wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation Loudon Park Cemetery 2-17-2010 Baltimore MD 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home Inc 1328 Sulphur Spring Road, Arbutus MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pheumonia **Physician** /Medical Due to (or as a consequence of) Examiner ive Pulmonary Disease nrunic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Severe Coronar and Due to (or as a consequence of): しりらのハ リヤイハにら Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the l IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No the 9 Unknown 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 4 Unknown 1 Tes 2 🗌 No 3 Probably director, page 2 should Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy frial Fibril 2 🔽 1 ☐ Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ဥ After this funeral 28a. Date of Injury (Month, Day, Year) ne Hospital or Attending Pin 24 hours after death. Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A: completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed aton Avenue Baltimore >hannarose 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

FEB 18

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 16. 2010 Dolores A. Dell'Angelo 2:35 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5822 Heron Drive Halethorpe B<u>altimore</u> Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Sept. 27, 1932 1 □ M 2 □ F Months Days Hours Mary Tand 218-28-2111 Director 77 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Marvland Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral 5822 Heron Drive 21227 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", Specify: White 3 - Widowed 4 - Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Account Department</u> <u>Bankine</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) <u>0</u> George William Gentry Mildred Μ. other traumatic . Page 1 and 2 shou tment of Health and tant; If item 27 is rr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Guido J. Dell'Angelo (Husband) 5822 Heron Dr., Halethorpe, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Loudon Park Cemetery ! 3/1/10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21, Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 6 3620 Wilkens Ave. Baltimore, Maryland 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC Physician, UNG CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a nonsequence of: if any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exami that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the SS IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ō Month Year Day Pregnant at time of death the Unknown signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hospital or Attending Physician; The law requires 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? this certificate 1 Yes 2 No Yes 2 X N 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{X}\) Residence 6 \(\sum \) Other (Specify, 1 🗌 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural 2 Accident 5 Pending work' death. 1 Yes 2 No Investigation within 24 hours after death To the Funeral Director; 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certif 29d. Date signed (Month. Day, Year)

State Registrar DHMH 17 Rev 7/2009 900 CATON AVE BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04385 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Mar Dhev Saran (V) 4:45P M Feb. 12, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Westminster

Westminster

If Under 24 Hrs. WestminsterRidgeAssistedLiving Carroll Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday **Funeral** Months Days Min 1 □ M 2 🗓 F Director 096-07-6764 Usual Residence of Decedent Jan. 28, 1914 New York 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evantmer must be notified at Director 1 ☐ Yes 27 No Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 505 High Acre Drive 21157 S.A 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2√2 No þ Specify: White 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hardware Store 12 Bookkeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Scharrer 2 Joseph Phillip Paul 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 0 0 1 4 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sl ment of Health an ant: If Item 27 Is r 1300Alexandra BLVD., Crystal Lake, Illinois <u>Carlton Depner</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any Injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Flushing Cemetery 2019-10 Flushing, 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee michael 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or compuse tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardiony Immediate Cause (Final ς **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed as the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed of Vital 1 ☐ Yes 2 **[]** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSP to 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation within 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated. 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type-Print) Way #106 Eldersburg MD 21784 1380

State Registrar 31. Date filed Month, Day, Year,

DHMH 17 Rev 1/2001

nor MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 Physician/ 03:35P M Medical Facility Name (if not institution, give street and n City, Town, or Location of Death Examiner Chellwood Road Baltimore MD 21209 BALTIMORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) URUGUAY **Funeral** Hours Min 0371071938 **Director** 084-30-0010 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Tes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6613 CHELWOOD ROAD 21209 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 X Married þ 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) IMPORTER COMPUTER TECHNOLOGY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ DAVIDSOHN MAXMILLIAN BELLA GITLI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETTY DAVIDSOHN / WIFE 6613 CHELWOOD ROAD, BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BNAI ISRAEL CONG. 2/17/2010 BALTIMORE, MD f Fundal Service 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or com ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only of Immediate Cause (Final Ph sician/ Iransitonal disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). the burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physician stached for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: P 2 **X**No 1 Tyes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural work? 5 Pending 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in first opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D36191 completed cause of death (Item 23a) (Type, Print) 10 N. Greene St. Baltimore 21201 State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7 | | 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February Physician/ Ehlenberger Marie 20TO Elinore 9:05 p. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Health & Rehabilitation Cntr Bethesda If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Mar. 31, Hours Min. Yea 1917 1 🗌 M 2 🔯 F New York Director .11**–**03–3878 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 No Bethesda MD Montgomery 10f. Zip Code 10g. Citizen of What Country? United States 10e, Street and Number 20814 Funeral 5721 Grosvenor Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give hours after 2 😾 No Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White Hygiene. other than "natural", XXWidowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygelee. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 æ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Theodora Elliott ည Charles Dampman Irwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 47768 Scotsborough Sq., Potomac Falls, VA 20165 Barbara Irwin Saia (daughter) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Feb. Date 18. Greenwood Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2010 Brooklyn, New York 4 Donation 5 Other (Specify) 22. Name and Address of FacilityRapp Funeral & Cremation Service 21. Signstura of Funeral Savice Licensee M00982 933 Gist Ave. Silver Spring, MD 20910 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between 23a. Part 1. Onset and Death Immediate Cause (Final Physician/ Malnutrition disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 10 yrs. Severe Alzheimer's Dementia Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Exami ed by the attending physician and detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🕏 No
9 ☐ Unknown Month Day Year 5 Other (specify) Pregnant at time of death g Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗆 Yes _2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 2 🕅 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29d. Date signed (Month, Day, Year) 29b. Signatu and title of certifier 29c. License number D 10493 address of person who completed cause of death (Item 23a) (Type, Print)
S. Saia, M.D. 1201 Seven Locks Rd., Suite 202, Rockville, MD 20854 S. Saia, M.D. 31. Date filed (Month, Day, Year) FEB 18 2010 32. Registrar's Signature State

Registrar

arke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of Ma	aryland			nt of Heal e of Dea			giene Reg. No	C 0 1 C	04388
	Physicia		1. Decedent's Name (First JAMES	st, Middle, Last,	COTTRELL		EATO	N .	JR.		2. Date of De Month FEBRU		5, 201	3. Time of Death 0 6:27 A M
	Medic Examin		4a. Facility Name (if not in	. 0	treet and number)	TAL			, Town, or Loca				County of Dea	ıth
Ī	Funeral Director		5. Social Security Numbe 134–28–4325	6. Sex		(In yrs. last	birthday) Yrs.		r 1 Year If U	Inder 24 Hrs.	8. Date of Bir (Month, Da Nov 18		9. Bi	rthplace (State or Foreign ountry) ⊇w YOrk
	and show dat	ρ	Usual Residence of Dece 10a. State 10b.	. County		10c. City, T	own or Loc	ation						10d. Inside City Limits
	Maryl 28a-f otifie	irec		rederic	k		Thur	_						1 ☐ Yes 2 X No
	with the 23a or ist be n	Funeral Director	10e. Street and Number 11324 Hess	song Bri	dge Road			10f. Zi	p Code 2178	88		10g. Ci	itizen of What C	ountry?
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the M-clical Examiner must be notified at ance.		11. Marital Status 1 Never Married 2 3 Widowed 4	2X Married	12. Was Decedent E Armed Forces? 1 \(\bar{\Delta} \) Yes 2 \(\bar{\Delta} \) If Yes, Give Year or Dates.		1 .		dent of Hispani cify Cuban, Me		ecify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit	
Baltimore, Maryland 21215-0036	within 72 hou glene. ter than "nat t, the M-dica	Completed by	15. (Specify of Elementary/Seconday 12	Decedent's Edu only highest grad y (0-12)	ucation le completed) College (1-4 or 5		(Give k		,	most of work	ing	16b. Kind of Business Industry unk		
land;	be filed v lental Hyg rked othe ic event,	To Be	17. Father's Name (First,		1 Eaton						Name (First, Middle, Maiden Surname)			
Mary	2 should Ith and Me 27 is mar traumati		19a. Informant's Name/F Emma Eaton							umber or Run	al Route Numbe	r, City or	r Town, State, Zi	
imore,	Page 1 and 2 s ment of Health ant: If item 27 ury or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cr 4 🛛 Donation 5 ☐	remation 3 🗆 F	Removal from State		e of Dispos etery, crem				Date	20c. L	ocation - City or	Town, State
Balt	permit. Departr Importa any inju		21. Sign was a funeral Kenta	7/////	101	ctor	I Ra	1+1-	oro MT	2120	11		ltimore	Street
23a. Park 1. Enter the disease, of complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition								r the mod	le of dying, suc	h as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
Santa	Medical Examiner	r.	resulting in death) Sequentially list conditio	ons,	Due to (or as a									
	cuted ind transit	xamine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or litijury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											
260	cate be executed physician and s the burial-transi'	ledical E												
P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affact death. Of the Funeral Director: Affact this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	₹	IF FEMALE: 23b. Was decedent pregr in the past 12 month 1 Yes 2 No 9 Unknown	ns?	3c. If yes, outcome of 1 ☐ Live Birth of 2 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal de	eath 3 🗌	Ectopic Other (s	pregnancy oec <i>ify</i>)				23d. Date of de Month	elivery Day Year
ds, P.O	v requires that the speen signed by should be deta	þ	Part II. Other significant	conditions cor	tributing to death bu	ut not resultin	ng in the un	nderlying	cause given in	Part I.				o the cause of death? Probably 4 ** Unknown
Division of Vital Records,	sician: The law rec certificate has be rector, page 2 sho	Completed				-					24a. Was autop perfo	osy rmed?	prior to death?	utopsy findings available completion of cause of s 2 \(\square \) No
ital	sician: certific rector,	m	25. Was case referred to examiner? 1 ☐ Yes 2 ☑ No	_	ospital:				Other:	Death (Chec				
n of V	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	cate: To	27. Manner of Death	Pending Investigation	1 Anpatie 28a. Date of injur (Month, Day,	y 28	Outpatient b. Time of injury		OA 4 2 28c. Injury at work? 1 Yes		ome 5 Resident Resident Personne 5 Resident Resi		Other (Specty occurred	cify)
Division	al or Attending s after death. Il Director: After ed in by the fune	Certificate:		Could not be determined	28e. Place of Inju- building, etc.		, farm, stre	et, factor	y, office		28f. Location (S City or Tow			ıral Route Number,
_	To the Hospital within 24 hours a To the Funeral t completed filled	Medical	(Check 2 \(\sum \) M	ledical Examin	cian: To the best of re: On the basis of ex Practioner: To the basis	amination an	d/or investi	gation, in	my opinion, dea	ath occurred a	t the time, date a	nd place	e, and due to the	cause(s) and manner stated.
	To the conjugate of the		- XII \	f certifier				290	C. License numl	ber			te signed (Mont	h, Day, Year)
					mpleted cause of de Bolarum				rial Ho	spital	Frede	/ rick	,MD.	
H	Stat Registra		31. Date filed (Month, Day	y, Year)	32. Registra				-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per verb., g900,02/18/2010dfb

Certificate of Death

Reg. No. 1 - For State Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) OZ Month **Physician** arkin dwaxd /Medical 4b. City, Town, or Location of Death County of Death Facility Name (If not institution, give street and number Examiner de edical Contre Houn 8. Date of Birth Min. (Month, Day,) Sep. 12, 5. Social Security Number 6. Sex Birthplace (State or Foreign
Country) 7. Age (In vrs. last birthday **Funeral** Hours Year Months Davs Virginia 1 XM 2 □ F 79 228-38-1947 Sep. 1930 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a State 10b County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. W. dical Evantiment to motify of any injury or other traumatic event, It. W. dical Evantiment to motify of any injury or other traumatic event, It. W. dical Evantiment to motify of any injury or other traumatic event, It. W. dical Evantiment to motify of any injury or other traumatic event, It. W. dical Evantiment to the contract to the contr 1 ☐ Yes 2X No Director MD Baltimore Lansdowne 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21227 United States 164 Stafford Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 XYes 2 No Korea Black White etc 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify. Specify: \$ 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) S. P. Richards Warehouse Handler 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Emiline Vass Larkin Letcher Edwards ဨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 16639 Heritage Hill Lame, Henderson, MD 21640 Vincent W. Edwards - Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2-9-2010 4 Donation 5 Other (Specify) Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility Ambrose Funeral Home, Inc. Arbutus, MD 21227 1328 Sulphur Spring Rd., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or a piratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HOUSS Cluxa disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner echanica Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examin and burial-trar The law requires that the death certificate be execu Due to (or as a consequence of) 68760 attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) the detached signed by t t be detach <u>ت</u> 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy perform certificate 1 ☐ Yes 2 No 1 ☐Yes 2 ☐ No Division of Vital Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To FRU OUT 27. Manner of Deat 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation 1 Natural Chair hit head Dry 03 15AM and 0204/10 1 ☐ Yes 2 No death. within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 3 ☐ Suicide 1004 6 □Could not be 28e. Plate of Injury - At home, farm, street, factory, office building, etc. (Specify)
H0SDITAL 281. Location (Street and Number or Rural Route Number City or Town, State)

2001 M.P.d. C., J. Parkuty Am 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed ca

State Registrar filed (Month, Day, Yea

FEB 18 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2010 D:30 AM ebinary 15 <u>Rolando Resma Evangelista</u> /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Agnes Hospital If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday 5. Social Security Number **Funeral** Days Hours Min. 1 M M 2 □ F 12/21/45 Phillipines Director 213-67-5617 64 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Madical Examinar must be notified at 1 ☐ Yes 2 No Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 USA by Funeral 4329 Alan Drive Apt. C 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Fillipíno Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 Is marked other the any injury or other traumatic event, the ince. Seaman Shipping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be <u>Maria Resma</u> <u>Domingo Evangelista</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wife 4329 Alan Drive Apt. C Baltimore, Maryland 21229 Mrs. Aida Q. Evangelista Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/17/10 Baltimore, Maryland Baltimore Crematory 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave. Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or coshock, or heart failure. List and lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician Anoxic day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner be executed Stage physician and s the burial-trans Due to (or as a consequence of): Box 68760 attending p IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) P.0. the 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown s been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an as S autopsy performed?

1 Yes 2 Wo page certificate Vital To the Hospitallor Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Medical Certification: To of 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. illedin by the fi 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined fter 4 Homicide hours within 24 hours To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Registrar

31. Date filed (Month, Day, Year) 32. FFR 1 9 2010

Répistar's Signature

ORIGINAL

			Please	State of M					All Copie Mental Hy		Legible		
			State Registrar			Cer	tificate of	Death		Reg. No.	2010	0 04391	
ı	Physicia Medic		Decedent's Name (First, Middle, La Bernard George	,					2. Date of De Month Februa	Day	16,20	3. Time of Death 1 0 4 : 0 6 A M	
	Examir		4a. Facility Name (if not institution, give	· ·			4b. City, Town, o	or Location of Dea			County of Dea	ath	
1			Gilchrist Hosp 5. Social Security Number 6.8			and to liable alone)	Towson		5 To Data # Dia		altimo		
п	Funeral Director			7. Ag 1 X M 2 □ F		ast birthday) Yrs.	Months Days		. (Month, Da		C	irthplace (State or Foreign ountry) Minnesot	
	3		Usual Residence of Decedent						1000.3	174			
	Maryland 28a-f show otified at	ctor	10a. State 10b. County			y, Town or Lo						10d. Inside City Limits	
	he Ma or 28a e notif	Dire	Maryland Balt 10e. Street and Number	imore	Ti	moniu	m 10f, Zip Code			10a Citis	zen of What C	1 🗆 Yes 2 🏋 No	
	/ith t 23a st be	Funeral Director	1261 Roundwood	Road, Ap	t.30	6	21093				S.A.	ouruy:	
	items		11. Marital Status	12. Was Decedent Armed Forces?		3. 13. V		Hispanic Origin? (S	Specify Yes or No-		14. Race - Am		
36	after o	by	1 Never Married 2 Married	1 Ves 2 If	No		Yes 2 TyNo		nto mican, etc.,		Black, Whi		
8	e hours aft "natural", dical Exa	etec	3 Widowed 4 Divorced 15. Decedent's B	Year or Dates.			A lent's Usual Occu				WIT	ite	
215	thin 72 h ine. than " n re Medi	Completed	(Specify only highest gas Elementary/Seconday (0-12)		5+1	(Give I	kind of work done O NOT use retired,	during most of we	orking	I I I I I I I I I I I I I I I I I I I	nd of Busines	s industry	
21	should be filed within 's hand Mental Hygiene.' 7 is marked other than traumatic event, the M			5+	J.,	Lieu	<u>tenant</u>	Colone	1	Uni	ted S	tates Army	
pue	e filed ntal Hy ed otf	To Be	17. Father's Name (First, Middle, Last)						ame (First, Middle,		,		
<u> </u>	ould b d Mer mark matic	[Vertus Wilhelm 19a. Informant's Name/Relationship (T 451 14 11		•	Van La				
Maryland 21215-0036	2 shouth and 27 is ritrau		Christina Mari						Rural Route Numbe	. ,	-	and21047	
ē,	1 and of Hea item other		20a. Method of Disposition	•		lace of Dispo	sition (Name of natory or other pla	!	Date		cation - City o		
Ë.	Page nent c ant: If ury or		1 ☐ Burial 2 😾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	J Removal from State ify)		-	rematio	: 2-	8-10 ces	Han	over,	Maryland	
Baltimore,	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		21. Signature of Funeral Service Licen	isee	•	22	. Name and Addre	ess of Facility M	Marzullo	o Fu	neral	Chapel,P.A	
	Physician/ Medical		23a. Part 1. Enter the disease, or conshock, or heart failure. List only disease or condition resulting in death)	one cause on each line	e. M	n. Do not ente	er the mode of dyin	ng, such as cardia		rest,	e,mar	Approximate Interval Between Onset and Death	
jd	Examiner cian and purial-transit	cal Examiner	resulting in death) Due to or as a contequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to or as a consequence of): C. Due to (or as a consequence of):										
D. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Feta	Ideath 3 🗆	Ectopic pregnan Other (specify)	су		2	3d. Date of do	elivery Day Year	
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Recor	The law recate has be page 2 sho	Somple							24a. Was auto perfo 1 \sum Yes		prior to death?	utopsy findings available completion of cause of	
tal	cian: ertific ector,	Be (25. Was case referred to medical examiner?	Hospital:				lace of Death (Ch		*			
Ž	Physic this c	2	1 Yes 2 No 27. Manner of Dea n	1 Inpati		ER/Outpatien	t 3 🗆 DOA j		Home 5 Resid			city hospeq	
0 4	ding I h. After funer	ate	1 Natural 5 Pending	28a. Date of inju (Month, Da	y, Year)	28b. Time of injury	28c. Injui wor M 1 [ryat k?]Yes 2 □ No	28d. Describe h	ow injury	occurred		
Division of Vital Records, P.O.	al or Attendi s after death. I Director: A d in by the fu		2	be Ose Diese of Init			eet, factory, office	163 2 110	28f. Location (S City or Tox		Number or Ri	ural Route Number,	
	To the Hospital within 24 hours To the Funeral completed filled	Medical	(Check 2/ Medical Exam	/sician: To the best of niner: On the basis of e rse Practioner: To the	xamination	and/or invest	igation, in my opini	ion, death occurred	d at the time, date a	nd place,	and due to the	cause(s) and manner stated.	
15	To the within To the Comp	2	29b. Signature and title of certifier	A A A A A A A A A A A A A A A A A A A	Social inly	.a.owiedge, C	29c. Licens		and due to th		signed (Mon		
			Malla	Mus			0	5 8 30 3	3	Feb	SURL	16 2010	
	•		30. Name and address of person who	completed cause of d	leath (Item	23a) (Type, P	rint) N - Cha	lest -	NORMOT	ng	7		
	Sta Registra	-	31. Date filed (Month, Day, Year) FEB 1 2 2010		ar's Sighati	bar.							
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DHMH 17 Rev 7/2009

Registrar

FEB 18 2010

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month February 14, 2010 Physician/ James Preston Fay Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Timonium Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland Social Security Numbe Age (In yrs. last birthday) 8. Date of Birth Funeral Hours Min (Month, Day, 59 Yrs Director Sept 216-52-4334 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director MD) Anne Arundel Odenton 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 2678 Streamview Drive 21113 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican. etc.) Armed Forces?

1 Yes 2 X No Black, White, etc. 1 X Never Married 2 Married þ Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Stable Employee Horse Racing Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Ellen Sierri Kauppinen William Lawrence Fay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) /sister PSC 303 Box 26 APOAP 96204 Ellen Sanna Foster Baltimore, FEBRUARY 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Arundel Crematory Feb 17, 10 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Donaldson Funeral Home & Crematory, P.A. 21. Signature of Funeral Service Licen M00773 1411 Annapolis Rd. Odenton, Maryland 21113 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Physician/ disease or condition LUNG CANCER Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Duo to (or as a nonsequence of): If any, eaching to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physiclan and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death 2 No cate has been signed by the a page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death. To the Funeral Director; After this certificate has t autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 X No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes X Natural 5 Pending 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7620 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JENNIFER HAUF. CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

10:15 PM

10d. Inside City Limits

Interval Between Onset and Death

Day

Year

1

Yes 2 □ No

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:41p M February 2010 Marguerite Irene Graves/Ausen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Gilchrist Center Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗶 F (Month, Day, Ye New Mexico Months Days Hours Min. Director 91 504-03-9500 Oct. Usual Residence of Decedent or 28a-f show notified at 10b. County 10a, State 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Maryland Howard Ellicott City 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 3020 N. Ridge Road, 21043 W - 304United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 🔀 No Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed rtment of Health and Mental Hr rtant: If item 27 is marked out njury or other traumatic even 2 John Joseph Schubert Amelia Mary Masgai 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4137 Red Bandana Way, Ellicott City, Maryland 21043 Lynn C. Donaldson/ Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 17 1 Burial 2 X Cremation 3 Removal from State Department or Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 2010 Metro Crematory, Inc. Baltimore, Maryland 21. Signature of Funeral Service License Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Seaso delly list our differin Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Dav 5 Other (specify) been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performe after death.

Director: After this certificate din by the funeral director, pag Yes 2 2 🗌 No 1 \square Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Tes 은 2 500 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate; 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Hospital Medical 29a. Certifier Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis or examination and on investigation, many opinion, scale and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2, To the F 29c. License number

DHMH 17 Rev 7/2009

State Registrar eted cause of death (Item 23a) (Type, Print)

21200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04395 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 10, 2010 11:30 AM Green Thomasine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Montgomery General Hospital Olney If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Yea
July 2, 1 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 M 2 X F Arkansas Director 382-12-9340 98 Usual Residence of Decedent show 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Michigan | Wayne Detroit 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 48227 U.S.A. 15829 Prest Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.

Department for Health and Mental Hygiene.

The macked other than "natural", or marked other than "natural", or any injury or other traumatic event, the Medical Examination or other traumatic event, the Medical Examination. by 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give 3 Divorced Completed Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Beautician Cosmetology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Henry Thomas Nannie Simril 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Damien Green (Son)</u> 5811 Prest St., Detroit, MI 48227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Donation 5 D Other (Specify) 2/17/2010 incoln Mem. Park Clinton Township, MI 22. Name and Address of Facility James Cole Funeral Home 2624 West Grand Blvd., Detroit, MI 48208 21. Signature of Funeral Service License we 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PIRATORY Medical resulting in death) Due to (or as a consequence of): Examiner PNEUMON Sequentially list conditions, if any, leading to immedicause. Enter Underlying Exami The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last DEMENIA Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Ectopic pregnancy been signed by the atte should be detached for Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 2 🔯 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🔀 No ျပ 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 \square Pending 1 Yes 2 🔲 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

68760 Box P.O. Records, of Vital Division

DHMH 17 Rev 7/2009

State Registrar

29b. Signature and tive of certifier

1091

Padmaja Bandi, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

00068026

18101 Prince Phillip Dr., Olney, MD 20832

29d. Date signed (Month, Day, Year)

10

Division

art II. Other significant conditions co	entributing to death but not r	esulting in the underlyi	ng cause given in Part I.		23e. Did tobacco use 1 Yes 2 V	e contribute to the c	
					24a. Was an autopsy performed? 1 Yes 2 ✓ No	24b. Were autopsy prior to compl death?	findings available etion of cause of
5. Was case referred to medical			26 Place of Death (Check	only o	one)		
examiner? 1 Ves 2 No	pital: 1 Inpatient 2	ER/Outpatient 3	DOA Other Nursi	ng Ho	me 5 Residenc	e 6 🗸 Other: Sce	ne
7. Manner of Death 1 ✓ Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day,Year)	28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d.	Describe how injury	occurred	
Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm, street, facto	ory, office building, etc.		Location (Street and or Town, State)	Number or Rural R	oute Number, City
9a. Certifier 1 ☐ Certifying Physician: check only ne) 2 ✓ Medical Examiner: Or	To the best of my knowled n the basis of examination a						use(s)

29c. License number

O.C.M.E.

State Registrar

29b. Signature and title of certifier

Margarita Korell MD.

Misoure

me Brile 30. Name and address of person who completed cause of death (Item 23a)

Medical

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Sanature

29d. Date signed (Month, Day, Year)

February 13, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04397 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Feb. 9, 2010 Cecelia Harris 2?30 a м 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Manor Care Woodbridge N/H Baltimore Baltimore 9. Birthplace (State or Foreign Country) Under 24 Hrs. 8. Date of Birth (Month, Day Year) 3 Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 □ F Months Days Hours 214-40-5317 96 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Baltimore 1 ☐ Yes 2 ☐ No 10e. Street and Number 3711 Oak Ave. 10f. Zip Code 21207 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces 1 ☐ Yes 2 ☐ No If Yes, GiveX Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ₩ Widowed 4 Divorced Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City 12th School Teacher 6yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Dennis Ruth Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Harris/daughter 3711 Oak Ave. Baltimore, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ardent Crematory 2/15/2010 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beverly D. Cromartie F/S 21. Signature of Funeral Service Licensee 2700 Edmondson Ave. Balto.,MD 21213 23a. Part V. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END STAGE KIDNEY disease or condition resulting in death) Due to (or as a consequence of): ARDIOVASCULAR DISEASE TPERTENSIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

and

physician

the

certificate

After this of funeral din

within 24 hours after death

To the Funeral Director;
completely filled in by the f

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hyglene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If the Modical Externine must be notified at any injury or other traumatic event, If the Modical Externine must be notified at

filed within 72 hours after death with Hygiene.

Baltimore, Maryland 21215-0036

/Medical

10a. State

Director

Funeral

þ

Completed

Be

ဂ္

MD

Examine burial-trai Physician/Medical the attending properties for use as use as is been signed by the should be detached þ

The law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

or Attending Physician;

To the Hospital

25. Was case referred to medical

Completed has be 2 s page Be

Certification: To

Medical

IF FEMALE: 23b. Was decedent pregnant

examiner? 1 ☐ Yes 2 No

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

4 Homicide

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28b. Time of 5 Pending investigation

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

31. Date filed (Me

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier M.D

6 ☐ Could not be

determined

D0059107

29d. Date signed (Month, Day, Year) 02-12-2010

REISTERSTOWN MD 21136

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar CENTER DRIVE

State of Maryland / Department of Health and Mental Hygiene 04398 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Lottie Pearl Horne February 2:00 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6150 Foreland Garth Apt. Howard 107 Columbia 6. Sex Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🛚 F Days (Month, Day, Year) 10-18-1930 Months Hours Min. Georgia Director 253-42-2141 Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Columbia MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6150 Foreland Garth Apt. 107 21045 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working 2 should be filed within 72 in and Mental Hygiene.
7 is marked other than "9 life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 House Wife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ Gaz S. Lewis Lillie B. Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sl tment of Health a tant: If item 27 is 9256 Hobnail Ct. Columbia, Maryland 21045 Robert K. Horne / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Pk. 02-24-2010 Meadowridge Mem. Elkridge, Maryland Signature of Funeral Service License 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 Rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 06 structi uronie disease or condition ear Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed 1 Yes 2 No al or Attending Physician: The safter death. Il Director: After this certificat completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number. determined the Hospital e Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier 29c. License number 81 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. EricBushmo 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Records,

of Vital

Division

Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Henderson James 2010 /Medical 4a. Facility Name (If not institution, give street and number) 21 Hampton Road County of Death
Anne Arundel 4b. City, Town, or Location of Death Linthicum Heights 4c. **Examiner** 8. Date of Birth (Month, Day, Year) Aug. 25, 1951 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 1 XM 2 ☐ F 214-54-5310 58 Yrs Director Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location ral", or Items 23a or 28a-f show Exportent must be octified at Director N/A Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 United States 3650 Greenvale Road permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Expulsion research once. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes X☐ No Specify: Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United Parcel Elementary/Secondary (0-12) College (1-4or 5+) Service Sorter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James William Henderson, Sr. Frances L. Pelter ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wanda L. Henderson - Wife 3650 Greenvale Road, Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place)
West Trematory
Crematory 20c. Location - City or Town, State 20a. Method of Disposition □ Burial 2 XCremation 3 □ Removal from State 2-9-2010 Odenton, Maryland 4 Donation 5 ☐ Other (Specify) Signature of Funeral Service Line 22. Name and Address of Facility Ambrose Funeral Home, Inc. 821 UN 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) End-Stage Renal Disease **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) burial-Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed' certificate 1 ☐ Yes 2 1 NO Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Thesidence 6 K Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 26 per doc g900 2-18-10 vt.

State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

2 No

29d. Date signed (Month, Day, Year)

2/4/10

son's

home

1 ☐ Yes 2 No

Virginia

White

4:00 AM

Year

the Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death. Division of Vital Records, filled in by the f To the Hospital of within 24 hours at To the Funeral D completely

N. S. Rajapakse, M.D 28355 mith Av., S-√32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

M5 Rajapakse M.D

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

Baltimore, MD. 21209

ORIGINAL

1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

203

29c. License number

D0057465

Petient known as! Denuld Johnson

			Please	Type or Print in				-		_	
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ω.	ifter d	F	11. Marital Status 1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give	10.0.	. Was Decedent of I If Yes, specify Cub		o Rican, etc.)		Black, White,	etc.
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Maryland	au si		19a. Informant's Name/Relationship (7)	ype. Print)	19b. Mail		t and Number o	ıral Route Numb	er, City or		ip Code) 212/6
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Baltimore,			20a. Method of Disposition 3 □ Cremation 3 □ I	Removal from State		ematory or other pla	ce) 02/_	1 1			MARYIAND
<u>=</u>	permit. Page Department Important: II any injury or once.		4 ☐ Donation 5 ☐ Other (Specify, 21 Signature of Funeral Service Licens		204445	CEMUTER 22. Name and Addre	ess of Facility 7%	1 / ~ 1			•
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			30. Name and address of person who co	ompleted cause of death (tem 23a) (Type	Print) Hosp		0 4 1	1	1	
		W 8	Patrick McGi	nley ML) - S.	mai Hosp	oital o-	+ Balt	t mo	12	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	hatel					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death **Physician** 2010 Colleen Jackson Ann February 11, 2154 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Hospice of the Chesapeake Anne Arundel Linthicum If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Months Days 1 □ M 2 🙀 F 218-78-0090 Director 53 Feb. 8, 1957 Maryland Usual Residence of Decedent 72 hours after death with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits s 23a or 28a-f show 10a. State Director 1 ☐ Yes 2 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 137 Clyde Avenue U.S.A. Funeral or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No 7 Is marked other than "natural", or items traumatic event, the Medical Examination Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify <u>≨</u> Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7; th and Mental Hygiene. **7 Is marked other than "n**. Elementary/Secondary (0-12) College (1-4or 5+) 12 Customer Service Manager Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gabriel G. O'Dougherty Winifred O'Brien ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an (Daughter) Jamey L. Aebersold 137 Clyde Ave., Baltimore, MD 21227 item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or c 1 Burial 2 K Cremation 3 Removal from State 2-16-10 4 □ Donation 5 ☐ Other (Specify) Orlando Crematory Orlando, FL 21. Sig lature of Funeral Service License 22. Name and Address of Facility MedCure P.O. Box 55730, Portland, OR 97238 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exerts. Due to (or as a consequence of): Examine requires that the death certificate be executed ending physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 ☐ Unknown the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page performe this certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1110 1 ☐ Yes 2 ☐ Mo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and oner stated

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

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hileted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1315 W. Jones Samuel Feb. 6,2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore City. Samaritan Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 3irthplau Country Va **Funeral** Months Days Hours 1**X** M 2□ F Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside Gity Limits 28a-f show traumatic event, the Medical Examiner must be notified at Ra HiMOre 1 Yes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? ō 21239 ntridge Koad items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 0 1 □Yes 2 □No þ If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 72 th and Mental Hygiene. 7 Is marked other than "na ondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname, 17 Father's Name (First, Middle, Last) Be ပ Baltimore Komaine of Health Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If it any Injury or o once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 160155 23a. Part 1. Enter the disease, or complications that caused the death. Do not ent 1 the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Severe **Physician** Due to (or as a consequence f): disease or condition resulting in death) /Medical Examiner nfected right Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of) rena 687600 physician been signed by the attending I should be detached for use as for use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
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9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Coronaur page 2 autopsy disease perform within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES 000 2010 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loch Raven Blvd, Baltimore 5601

State Registrar Nandini

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32. Registrar's S

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Mic Physician/ David Francis Johnson 4;44PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Surnie 8. Date of Birth (Month, Day, May 20, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F Hours Min. Country) Utah Director 529-16-3697 89 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examinar must hamorisman. 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 No MD Anne Arundel Severna Park 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 472 Ledbury Road 21146 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

14 Yes 2 If Yes, Give Black, White, etc. 1 Never Married 2 Married δ 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. 42-45 Specify: white 3 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) 12 economist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bess V. Day Joseph F. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 472 Ledbury Road Severna Park, MD 21146 Ruth Johnson/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signalur of Euneral ervice Licensee Renald S. Wa State Anatomy Board 655 W. Baltimore Street Director MD Baltimore 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) Medical Due to (or as a consequence of) Examine aur Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran the attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death cate has been signed by the spage 2 should be detached 1 L Yes 2 L 9 L Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Johnson 24b. Were autopsy findings available prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has k completed filled in by the funeral director, page 2 s autopsy performe 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 🗆 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 \square Pending work? 1 ☐ Yes 2 ☐ No - atura Investigation
6 Could not be Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month P^{M} Kevin Howard Kotzen February 3:03 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Baltimore County 2311 Falls Gable Lane Apt. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Country)
Washington DC Director 220-82-6682 40 Usual Residence of Decedent at 10a. State with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director ms 23a or 28a-f sl must be notified 1 Yes 2 X No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2311 Falls Gable Lane Apt N 21209 United States : If item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner mu death √ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces 7 Black, White, etc. 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify. 3 Divorced 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 4 Car Salesman Apple Ford Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward B. Kotzen Sharon B. Parzow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Patricia Kotzen / Step-Mother <u>1638 Bayside Drive Chester, Maryland 21619</u> Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 4 Donation 5 Other (Specify) Meadowridge Mem. Park 02-17-2010 Elkridge, Maryland 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.

Donaldson Funeral Home & Maryland 21113 Sign uur of Funeral Ser Annapolis Road Odenton, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Ph sician/ Suraide (Jun Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death 5 Other (specify) Month Day 1 ☐ Yes 2 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has performed 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 1 Yes Other: ၉ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Nesidence 6 Other (Specify) 4 28a. Date of injury (Month, Day, Year) Certificate: . Manner of Death 28c. Injury at work? 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred Sund injury 1 🔲 Natural 5 Pending 15037 2 No February 7,2010 ho Accident Investigation within 24 hours after deat To the Funeral Director. 6 Could not be 3 Suicide 4 Homicide 281. Location (Street and Number or Bural Route Number, City or Town, State) 231 Fall Gable Lane Pikesulle, MD 21209 28e. Place I Injury - At home, farm, street, factory, office building, etc. (Specify) determined Home Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and 29c. License number 29d. Date signed (Month. Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 . Registrar's Signati State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04405 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Jiviben R. Kadiwar February 2010 10:15 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Derwood 18140 Hayloft Drive Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗓 F Months Hours Min (Month, Day, Year) 01-01-1919 Director India 216-73-5103 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Derwood 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20855 18140 Hayloft Drive India 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 XWidowed 4 ☐ Divorced Completed East Indian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home Maker permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important; If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bhovanbhai Santoki Motiben Santoki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18140 Hayloft Drive Derwood, Maryland 20855 <u> Jayantilal Kadiwar / Son</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory 02-20-2010 Odenton, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, <u>1411 Annapolis Road Odenton, Maryland</u> Part 1 Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cerebral Vascular Accident Hours disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit Exami Cause (Disease or iinjury that initiated events that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 24 No 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a 1 Yes 24 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number MARYLAN)
DO030832 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar DHMH 17 Rev 7/2009 JayantiIal

31. Date filed (Mg

Baltimore, Maryland 21215-0036

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Box

P.O.

Records,

of Vital

Division

18140 Hayloft Drive Derwood, Maryland 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Registrar's Signature

Kadiwar,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February Physician/ 2010 1:19A M Deborah Kelch Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie 1207 Whitman Drive Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day g, Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 2 🗓 F Hours Mary Land Director 214-62-6047 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

tant: If item 27 is marked other than "natural", or items 23a or 28a-f show jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 USA 1207 Whitman Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Completed by 1 Never Married 2 X Married 2 XNo ☐ Yes Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 <u>Maintenance</u> Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alice Rae Martin Charles Mohl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Kelch, Sr.-husband 1207 Whitman Drive, Glen Burnie MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🗌 Burial 2 🖎 Cremation 3 🗌 Removal from State West Arundel Crematory 2-18-2010 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home of Lansdown 2719 Hammonds Ferry Road Lansdowne MD 21227 and a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death MOLEAS shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner quantially fist conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 ☐ No 1 ☐ Yes 2 ☐ Unknown 9 Unknown filled in by the funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 ☐ No 3 🗹 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed' Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ ER/Outpatient 3 DOA 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 5 \square Pending 1 Natural 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the cause of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completed (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and Itle (3 certii D0058779 16 2010 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL DR. Glen Barnie KASAMON 305 31. Date filed (Month, Day, Year) Registrar's Signature State EB 1

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Diane Month Dav Physician/ Moore 1119 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ba (timere thospipel Baltimore OF-If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 63 Months Yrs. 28/1946 MAIKAAN **Director** Usual Residence of Decedent 10d. Inside City Limits of Health and Mental Hygiene. item 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State should be filed within 72 hours after death with the Maryland Completed by Funeral Director 1 Yes 2 ☐ No Himare 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21310 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify: Blac 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ antence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltmore, Marikard 21211 kan L. Craia Page 1 and 2 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1
Department of I
Important: If it
any injury or of ō cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 03/33/30/0 Be/4/more/kn/kinc 4 Donation 5 Other (Specify) Derruk C Jones Fill Signature of Funeral Service Ligenses 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Due to a as a consequence of): Physician disease or condition resulting in death) Medical Examiner Scoot tally list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Due to (ours a consequence of): for use as the burial-transit Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) detached 9 Unknown Records, P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed within 24 hours a 'er death.

To the Funeral Director. After this certificate has been siy completed filled — by the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Cerronary
25. Was case referred to me cal arting 1 Yes 2 No 26. Place of Death (Check only one) Division of Vital Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ္ 1 Impatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one d fittle of certifier 29b. Signature ar RE3-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hosmal & Baltimore Berttimen LUD 2/24 s Signature 31 Date filed (Month, Day, State Registrar

Physician /Medical Examiner The law requires that the death certificate be executed the burial-tra Box 68760.

altimore, Maryland 21215-0036

show r 28a-f sh notified

attending physician for use as the burial signed b After this certificate has funeral director, page 2 Certification: To hin 24 hours after death the Funeral Director:

Division or Vital Records, P.O.

or Attending Physician:

the Hospital

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier DIANET N. MYERS, MD PHYSICIAN 29c. License number 0101051315 29d. Date signed (Month, Day, Year) 13, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Myers, MD 8901 Wisconsin Ave Bethesda MD 20889 #32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

filled in by

			Amend 20b, Please T	y986°27187	in Bla	ck Indeli	ble In	k. Ensure	All Copie	s Are Leg	jible.	
			For State Registrar	State of Man	yland /	Departme Certifica			Mental Hy	giene Reg. No. 20	10	04409
	Physicia	an/	1. Decedent's Name (First, Middle, Last)	- 1	11				2. Date of Do		Year	3. Time of Death
×g.	Medi Examir	cal	4a. Facility Name (if not institution, give str		1040		tv. Town. o	r Location of Death	FEB: 1	4c. County	2	1; 45 PM
4			Good SAMARS	TAN A	tosp		BA	ito		1	114	
	Funeral Director		5. Social Security Number 6. Sex 1 \Box	M 2 🕱 F	yrs, last bi	Yrs. If Und Month	der 1 Year s Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth ay, Year)	9. Birth Cour	place (State or Foreign
	und show at	ō	Usual Residence of Decedent 10a. State 10b. County	10	oc. City, Tov	vn or Location						10d. Inside City Limits
	Maryla 28a-f s otified	Director	MD NI	4	BI	CTEM	RE					1 Yes 2 □ No
	with the 23a or st be n	ral D	10e. Street and Number	IN RO	/	10f. 2	Zip Code	1214		10g. Citizen of	What Cou	ntry?
•	death vitems	Funeral	11. Marital Status 1	2. Was Decedent Ever Armed Forces?	in U.S.	13. Was Dec	edent of H	ispanic Origin? (Span, Mexican, Puerto	pecify Yes or No			can Indian,
036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates.				Specify:	o nican, etc.)		ck, White,	
5-0036	2 hours "natur edical	Completed	15. Decedent's Educ (Specify only highest grade	ation	168	a. Decedent's Us (Give kind of w		ation during most of wor	kina	16b. Kind of B	usiness In	dustry
212(vithin 7 jiene. r than the Me		Elementary/Seconday (0-12)	College (1-4 or 5+)	7	life. DO NOT U	se retired)	935Z5 fr	ent	HAME	ECH.	t SOLTEL
pug	d 2 should be filed within 7 alth and Mental Hygiene. 127 is marked other than er traumatic event, the M	To Be	17. Father's Name (First, Middle, Last)	7				18. Mother's Nar		, Maiden Surname		
aryland	nould brind Mer s mark		19a. Informant's Name/Relationship (Type	Print)	19	b. Mailing Addre	ss (Street a	and Number or Ru		er. City or Town. S		
E	and 2 sh Health a em 27 is ther tra		DENISE THOMPSON,	benovale!	1162 4	1807 1	216x	en Rd-				
Baltimore,	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		20a. Method of Disposition 1 ◯ Burja 2 ◯ Cremation 3 ◯ R 4 ◯ Donation 5 ◯ Other (Specify)		20b. Place of cemeter	of Disposition (Nerv. crematory or Carme)	ame of other place مرمد ح	ie) 2/	Date 19/10	20c. Location	•	
3altii	permit. Page 1 a Department of I Important: If ite any injury or ot		21. Signature of Funeral Service Licensee		, XXXII	22. Name	and Addres	ss of Facility	ETTS ,	FUNER		
Ë			23 Part 1. Enter the disease, or complic	Mons that caused the	death Do	1129	nde of dvin	CARNEN	or respiratory a		120	Approximate
-4	hysician/		shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.	0 50%	purfic	1	rele ve		-7~	ease	Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a co	nsequence	of):	0120	1000		9.0		Years
	7 ±	iner	Sequentially list conditions, b. if any, leading to immediate cause. Enter Underlying	Due to (or as a co	nsequence	of):	7	ewsii C				jews
	executed ian and irial-transit	Examiner	Cause (Disease or iinjury that initiated events c. resulting in death) Last	Due to (or as a co	nsequence	of):						
09		dical	d.									
Box 68760	certifica nding p	n/Me	IF FEMALE: 23b. Was decedent pregpant 23c	:. If yes, outcome of p						23d. Da	te of deliv	erv
Box	hat the death certificate be ed by the attending physic detached for use as the bu	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown		th 3 Ectopic 5 Other (:y			nth	Day Year
P.O.	Physician: The law requires that the death certificate be this certificate has been signed by the attending physic ral director, page 2 should be detached for use as the bu	by Ph	Part II. Other significant conditions conti	21	ot resulting	in the underlying	g cause giv	en in Part I.	23e. Did t	obacco use contr	ribute to th	ne cause of death?
rds,	w requires that so been signed to should be detailed.	eted	- i)	whe for					1 🗆			bably 4 Unknown
seco.	ne law r te has b age 2 sl	Completed							24a. Was auto perfe	psy ormed?	orior to co death?	psy findings available mpletion of cause of
tal F	cian: The	Be C	25. Was case referred to medical examiner?	- 24 - 1.				ace of Death (Chec		2 No	1 🗌 Yes	2 L1No
of Vi	Physic r this c eral dire	e: 10	27. Manna of Death	28a. Date of injury	28b.	utpatient 3 🗆 I	Othe 28c. Injury	4 U Nursing H		dence 6 Other)
ion	tending leath. tor: Afte the fun	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Ye	ar)	injury M	work					
Division of Vital Records,	al or At s after o I Direct d in by		4 Homicide determined	28e. Place of Injury - building, etc. (Sp	At home, fa	arm, street, facto	ry, office		28f. Location (City or Tox	Street and Numbe vn, State)	er or Rural	Route Number,
_	To the Hospital or Attending Physician: The law within 24 Hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s	Medical	29a. Certifier (Check 2 Medical Examiner	On the basis of exami	nation and/	or investigation, in	n my opinio	n, death occurred a	at the time, date a	and place, and due	to the car	use(s) and manner stated.
;	To the within to the comple		only one) 3 Certifying Nurse F 29b. Signature and title of certifier	ractioner: To the best	of my know	/ledge, death occ	urred at the	e time, date and pla	ce, and due to the	e cause(s) and ma	inner as st	ated.
0			* Bullat 1 12-				13	8543		rehnu	uvy.	11,2010
			30. Name and address of person who com	pleted cause of death	(Item 23a)	(Type, Print) Of Lite	L Ra	ven Beli	leverel	Bulto	will	oay, Year) 11. Je io 11735 Mangloud
	Stat Registra	re.	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature	1 4.	ed.					/
			EER 10 20	III Theres	19	IN CLASE	Salar Salar					

ORIGINAL

Paullette Maple		State of Maryland / Departme 1- For State Certifica Registrar	ent of Health and Mental F lite of Death	lygiene Reg. No	2010	04410		
Physician Medical Examine		1. Decedent's Name (First, Middle,Last) Paulette Maple		2. Date of Death Month Day February 10, 2	Year	ime of Death 613 hrs		
*****		4a. Facility Name (if not institution, give street and number) 3023 McElderly Street	4b. City, Town, or Location of Deat Baltimore		c. County of Death			
Funeral Director		5. Social Security Number 213-84-5830 6. Sex 7. Age (In yrs. last birth			1/DD/YYYY) 9. Birthplac			
rland -f show any once.		Usual Residence of Decedent	more		1 [Inside City Limits Yes 2 No		
the Mary a or 28a utified at	Director	10e. Street and Number 3023 Mc Elderly St.	10f. Zip Code 21205	US	tizen of What Country?			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itiem 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerton 1 Yes 2 No specify:	o Rican, etc.)	14. Race - American Ir White, etc. Specify: Blac			
7036 within 72 hours lene. Medical Exam	mpleted	College (1-4 or 5+) College (1-4 or 5+) N / A College (1-4 or 5+) College (1-4 o	ecedent's Usual Occupation (Give kind of uring most of working life. DO NOT use rel	tired)	Kind of Business/Indust	ny		
215-(be filed v ntal Hygi rked oth	8	17. Father's Name (First, Middle, Last) Jerome Maple	18.Mother's Nam Elizabe	ne (First, Middle, Maider eth	Watkins			
MD 21 2 should h and Mer 27 is mai	2	19a Informant's Name/Relationship (Type, Print) Tyrone Maple/brother 19b. 2	Mailing Address (Street and Number or 101 Woodyear Ba	Rural Route Number, Caltimore,	ity or Town, State, Zip of MD 21217	Code)		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filted within 7 Department of Health and Mental Hygiente. Important: If tiem 27 is marked other than injury or other traumatic event, the Medica		1 Burial 2 Cremation 3 Removal from State Arden 4 Donation 5 Other Specify:		15/2010	Location - City or Town	MD		
Ball permit Depart Impor injury	ļ	21.8 ignature of Funeral Service-tigensee	22. Name and Address of FacilityBev 2700 Edmondson	verly D. (Ave. Bal	Cromartie to., MD 2	F/S 1223		
Physician /Medical								
Examiner.		or condition resulting in death) Due to (or as a consequence of): qu Sequentially list conditions, b.	etiapine) intoxica	tion				
50, le be executed ysician and burial - transit	xaminer	If any, leading to himediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last						
60, are be executed hysician and e burial - transit		d AMENDED 220 27 280	f nomE 0001 2/2/	1 A True				
6876 certifical nding ph	sician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5 Unknown	Fetal death 3 Ectopic pregn Other (Specify)	23	d. Date of delivery Month Day	Year		
P.O. Es that the gned by the detached	oy ruy	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.		use contribute to the ca			
Records, P.C. The law requires that rate has been signed bage 2 should be deta	ompieted			24a. Was an autopsy performed?	death?	findings available etion of cause of		
f Vita	0 00	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Til	me of Injury 28c. Injury at Work?	ing Home 5 Reside	ence 6 🗸 Other Scer	ne		
Divisior Spital or Attend nours after death nersal Director: filled in by the	Certification:	2 Accident 3 Suicide 4 Homicide Accident 5 Fending Investigation 6 X Could not be determined Could not be determined (Specify) Fd 2/10/10 Fd 2/28e. Place of Injury - At home, farm (Specify)	4:00 pm 1 Yes 2 X No m, street, factory, office building, etc.	unk 28f. Location (Streets or Town, State) Baltimore.	and Number of Rural Ro 1023 McElde MD	oute Number, City		
Div To the Hospital of within 24 hours at Within 24 hours at To the Funeral D completely filled	ਜ਼	29a Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or invand manner stated				se(s)		
2	Me	29b. Signature and title of certifier	29c. License number O.C.M.E.		Date signed (Month, Di	ay, Year)		
pend	1	30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn	Street, Baltimore, MD 21201					
Stat Registra	te ar	31. Date filed (Month, Day Year) FEB 18 2010 32. Refistrar's Signature	4.00	·-·		_		
DHMH 17 Rev 1/200			SINAL)CA4E			

10-01185 Telebrard Miller	en con	Please Type or Print in Black Indelible Ink. Ens State of Maryland / Department of Health			4	0 111 1 1		
Div!-!		1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last)	— т	Re-	0	3. Time of Death		
Physici Medical Exami				Month February 9		0610 hrs		
		4a. Facility Name (if not institution, give street and number) Johns Hopkins Hospital 4b. City, Tow Baltimore	n, or Location of Death		4c. County of Death			
Funeral Director		390-12-3007 1XM 2 F 80 Yrs.	Year If Under 24Hrs. Days Hours Min.	-	n(MM/DD/YYYY) 9. Birt Foreig Cou			
id how any cc.	ŗ	Usual Residence of Decedent 10a. State 10b. County Maryland Queen Anne's Chester				10d. Inside City Limits 1 X Yes 2 No		
the Maryland or 28a-f show tiffed at once.	Director	10e. Street and Number 10f. Zip Co	21619	10	g. Citizen of What Coun	try?		
5-0036 6 within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 X Married 1 Never Married 2 X Married 1 X Yes 2 No 1 Widowed 4 Divorced of Pates: WWII 1 Yes 2 X	of Hispanic Origin? (Spe Cuban, Mexican, Puerto F No specify:	Rican, etc.)	14. Race - Americ White, etc. Specify: Whi	te		
5-0036 led within 72 hours afte Hygiene. other than "antural" the Medical Examine	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4+ Scientification (Specify only highest grade completed) during most of working the secondary (0-12)	cupation (Give kind of wo ng life. DO NOT use retire ntist		16b. Kind of Business/Ir USDA	ndustry		
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than safte event, the Median	Be	17. Father's Name (First, Middle, Last) Henry Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (3)	18.Mother's Name (rnad		Zin Code)		
at is	7		Maria Aveni					
Per in it		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of Crematory or other place) Ceorge Washington (Date 1/2010	20c. Location - City or Adelphi, M			
Baltimc permit. Page Department Important:		21. Signature of Funeral Service Licensee 22. Name and Ad	Idress of Facility Funeral Hom	4 ne P.A. H	739 Baltimo	re Avenue		
Physician /Medical /Examiner	/Medical Immediate Cause (Final disease a. Head injuries							
	L	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.						
+	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):						
executed an and al - transit	g	d. X UNPENDED AMENDED AMENDED AMENDED AMENDED						
	Med	AMENDED 23a,27,28a-f,per ME g904 IF FEMALE: 23c. If yes, outcome of pregnancy	6/15/10 TT		23d. Date of delivery			
Box 68760, edeath certificate be the attending physic of for use as the bur	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1	3 Ectopic pregnan	ncy	Month D	ay Year		
i, P.O. B ires that the de signed by the	ò		use given in Part I.		pacco use contribute to t			
cords, aw requir has been s	Completed			24a. Was a autops perform	y prior to coned? death?	opsy findings available ompletion of cause of		
tal Recion: The I certificate	Be	25. Was case referred to medical 26.F	Place of Death (Check or					
n of Vital I ding Physician: h. : After this certifi : funeral director,	<u>1</u>	examiner? 1 Yes 2 No 1 No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c.	. I I I I I I I I I I I I I I I I I I I		Residence 6 Other:			
Sion of Attending Ph death. ector: After 1	cation	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation Fd 2/9/10 unk		unk		- N - N - 0'		
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	Certification	3 Suicide 6 K Could not be determined 28e. Place of Injury - At home, farm, street, factory, off (Specify) house	rice building, etc.	or Town, St.	28f. Location (Street and Number or Rural Route Number, City or Town, State) 108 Brown Road Chester, MD			
To the Ho within 24 J	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my op and manner stated.	pinion, death occurred at		nd place, and due to the	e cause(s)		
	Σ		icense number D.C.M.E.		29d. Date signed (Mon February 27, 201			
		L	treet, Baltimore, M	D 21201				
St Regis	tate trar							
DHMH 17 Rev 1/2 OCMF 2006		ORIGINAL		444	*			

DHMH 17 Rev 1/2001 OCME 2006

Month **Physician** Morrison /Medical 4a. Facility Name, (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ne 96 CHTER chda If Under 1 Year | If Under 24 Hrs. 6. Se 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 5. Social Security Number **Funeral** Year) Days Min Months Hours 12 M 2 □ F Yrs 490-18-7872 88 12-05-1921 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at by Funeral Director Pikesville Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 4775 Bonnie Brae Road 21208 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married jo, Baltimore, Marvland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced "naturai" Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Goodyear Tire Maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lipiny or other traumatic event once. ည Benjamin F. Morrison Minnie 19a. informant's Name/Relationship (Type. Print) Iris Turner(Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Joseph Brown F/H
And Crematory 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line ardiac Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗆 Ectopic pregnancy 5 Other (specify) 1 ☐Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ Completed 1 ☐ Yes 25. Was case referred to medical Be examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manger of Death 28c. Injury at Work? 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29b. Signature and title?

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Ford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4775 Bonnie Brae Rd., Pikesville, MD 21208 20c. Location - City or Town, State 02/19/10 | Baltimore, MD Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1000 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) park

Reg. No. 20

Day

Year

4,2010

4c. County of Death

U.S.A.

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐Yes 2 ☑No

Missouri

14. Race - American Indian,

Black, White, etc.

Specify: Black

2. Date of Death

Registrar DHMH 17 Rev 1/2001

State

Steven 31. Date filed (Month, Day, Year)

1 - For State Registra

1. Decedent's Name (First, Middle, Last)

10-01253	
Jonathan	Maxwell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 0 | 4 | 3

		Registrar		Ce	rtificate	e of L	Jeath				Reg. No.			
Physicia		1. Decedent's Name (First, Midd	lle,Last)							Date of De Month	ath Day	Year		3. Time of Death
edical Exami	iner	Johnathan	David	M	axwe1	.1			F	ebruary	11, 2	010		1219 hrs
		4a. Facility Name (if not institution	on, give street and numb	ber)		4b	. City, Town, or	Location o	of Death		40	c. County of	Death	
		2314 Martin Lane					Joppa				H	Harford		
Funeral		5. Social Security Number	6. Sex 7.	. Age (In yrs. I	last birthda	y)	If Under 1 Yea	r If Under	r 24Hrs.	B. Date of B	irth(MM	/DD/YYYY)	9. Birtl	hplace (State or
Director		255-53-6432	1 M 2 F	29		.	Months Day	s Hours	Min.	July 2	26.	1980	Foreign	n total
			1 1 M 2 F			Yrs.				, 41,	-+ ,	1,00	000	n©eorgia
ž.		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or L	ocation	`							10d. Inside City Limits
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land f sho	ō	GA Ocone	3e	W	atkin									
Mary 28a-	Director	10e. Street and Number				- 1	10f. Zip Code				-	izen of Wha	t Coun	try?
death with the Maryland or items 23a or 28a-f show must be notified at once.		1040 Crooked (Creek Ct.			- 1	306	77			U			
with	Funeral	11. Marital Status	12. Was Deced				Decedent of His				lo-			an Indian, Black,
eath iter	nne	1 Never Married 2 M	Armed Forc	- L J J		If Yes	, specify Cuban	i, Mexican,	Puerto Ric	an, etc.)		White,	etc.	
		3 Widowed 4 Div	vorced If Yes, Give Year	² 200	5 1	1 🗌 Y	es 2 ^X No	specify:				Specify:	Wh:	ite
urs a tura amin	Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business									iness/Ir	ndustry			
during most of working life. DO NOT use retired)														
hin 7 e. edica	Completed		2		La	nds	cape De	signe	er		L	ansca	pe l	Design
5-0036 led within 7 Hygiene. I other than the Medica	ē	17. Father's Name (First, Middle	Last)					-		rst. Middle.		Surname)	r	
The Hard	Bec	David Thomas N							inda (,		
21215-003 ould be filed within Mental Hygiene, marked other the cevent, the Med	To B	19a. Informant's Name/Relations			19b. M	ailino A	ddress (Stree				ımber C	ity or Town	State	Zin Code)
MD ; d 2 shou lth and I n 27 is 1	-	David Thomas N		ather			Crooked							
Z had 2 M		20a. Method of Disposition	idawell le				on (Name of cer			ate		Location - (
of H		1 X Burial 2 Cremation	n 3 Removal from	Glate	crematory			- 1					•	
Pag Pag nent iant:		4 Donation 5 Other S	pecify:	0c			. Park		2-17	7-10	Wa	tkins	vil.	le, GA
Baltimore, permit. Pages I at Department of He Important: If ite injury or other tr		21. Signature of Funeral Service	Licensee			22. Nar	ne and Address	of Facility	'	12	11 J	immy :	Dan:	iel Road
E. E. O. & CO		Jun D	Levek	2		Lor	d & Ste	phens	s FH	Воя	gart	, Geo	rgia	a 30622
Physician		23a. an I. Enter the disease, or failure. List only one cause		sed the death	. Do not er	nter the	mode of dying,	such as ca	ardiac or res	spiratory ar	rest, sho	ock, or hear	t	Approximate Interval Between Onset and
/Medical.	1.8	Immediate Cause (Final disease	N. Minda Indian	ies										Death
Examiner		or condition resulting in death)	Due to (or as a co		f):									
•		Sequentially list conditions,	b											
	je	if any, leading to immediate	Due to (or as a co	onsequence o	f):									
	Ē	cause. Enter Underlying Cause (Disease or injury that initiated	С		6 .									
ed nsit	Examine	events resulting in death) Last	Due to (or as a co	onsequence o	т):									
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and implicely filled in by the funeral director, page 2 should be detached for use as the burial - transit		LINDENDED	d.											
760, ficate be exe g physician a the burial -	n/Medical	UNPENDED	AMENDED											
68760, certificate bo nding physic se as the bur	Ž	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, out			1					230	d. Date of d		
68° certifi	iar	past 12 months?	I LIVE DILL	n It at time of de	2 ath 5	7	death 3	Ectopic	pregnancy			Month	Da	ay Year
Sox 68 leath certi e attendin for use a	Sic	1 Yes 2 No 9 Un	known 9 Unknown		5	Othe	r (Specify)							
D. B.	Physiciar	Part II. Other significant condit			esulting in	the und	leriving cause o	iven in Par	rt I.	23e. Did	tobacco	use contrib	ute to th	ne cause of death?
P.O. es that the gened by	百		3				, ,			1 \ Y6	s 2 V	No 3	Proba	ably 4 Unknown
tal Records, P.(cian: The law requires tha certificate has been signed ector, page 2 should be det	Completed									24a. Was				opsy findings available
w rec	흺									auto	psy	pri	or to co	mpletion of cause of
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n: T		25. Was case referred to medica	il I		-	_	26.Place	of Death (Check only					
of Vital Records, and Physician: The law require wher this certificate has been signed irrector, page 2 should be meral director, page 2 should be a second of the control	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpa	atient 2	ER/Outpa	tient 3	DOA	Other4	Nursing Ho	ome 5	Reside	nce 6 🗸	Other:	Scene
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nding th.	ertification:	1 Natural 5 Pend	28a. Date of (Month, Date)	No Gear)	1208 hr	s	1 🗸 Y	es 2	No Sul	bject str	uck an	d pinned	unde	er a bob cat
Division is of a strenging the strength of the	cat	2 🗸 Accident Inve	stigation	of Injury - At he	ome farm	street	factory, office b	uilding etc	28f	Location	(Street a	nd Number	or Rur	al Route Number, City
Divisospital or A hours after meral Dire	뛴	dete	Id not be rmined (Specify)		ome, ram,	311001,	ractory, office b	dildilig, etc.		or Town,	State)		OI IVair	ar reduce reamber, only
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To the Howithin 24 h To the Fur	Medical		and manner state	ed.		90.00				o, vale				
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		Coller	2115	4	7,		O.C.N	M.E.			Feb	ruary 12	2010)
	ı	30. Name and address of person	who completed cause	of death (Item	23a)				,			-		
		Zabiullah Ali, M.D.	Assistant Medical	Examiner	1111	Penn	Street, Balti	imore, M	1 D 21201	1				
St	ate	31. Date filed (Month, Day, Year)	32 Regis	strar's Signatu	ice /	6000	2S					- · · · · - · -		
Regist														

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar amend 1 4/23/10 Lb Registrar amend 1 per Dr. g902

Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Baby Cirl Morris Keirslin Sharon Anderson **Physician** JANUARY 2010 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** Days Hours 1 - M 2 - F Jan 29, infant 2010 Director Maryland Usual Residence of Decedent death with the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Director MD Baltimroe Yes 2 No 10e. Street and Number Of. Zip-Code 10g, Citizen of What Country' 23a or 5689 Purdue Acenue 1D 21239 Funeral or items Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itel may injury or other traumatic event, the Medical Examiner one. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify þ Specify: black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) infant infant infant infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kimberly D/ Morris James Leon Anderson ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) The Johns Hopkins Hospital 600 N. Wolfe Street Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 N Othen (Specify) in state 21. Signature Funeral Second Romand ce License 22. Name and Address of Facility 22. Name and Address of Facility

State Anatomy Board 655 W. B

Baltimore, MD 21201

23a. Part V. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Between Onset and Death Immediate Cause (Final Physician as a consequence of): disease or condition resulting in death) extreme /Medical Due to (or **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 🗌 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) d by the ar 2 No Division of Vital Records, P.O. 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No ate has page 2 2 No certificate Yes 1 Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital 1 Inpatient 2 ER/Outpatient 3 DOA မ this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 Natural 5 Pending investigation Injury e Funeral Director Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide City or Town, State) 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (check only one) completely 2 - Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD RES-000 10 sho. 2 person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of 600 North Wolfe St, Baltimore, MD, 21287 Registrar's Signa State

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Registrar

Back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 30 PM Andrea Louis Mastellone Phragry /Medical 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner rave Losedale saltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 🕱 M 2 🗆 F Months Hours 212-30-1668 Director 85 3-1-1924 Italy Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 □Yes 2 No Director Baltimore MD Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 4304 Camellia Road 21236 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mastellone Deli Grocer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mastellone Salvatore Immacolata Veniero ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Margaret Rose Mastellone 4304 Camellia Road Perry Hall, Md. 21236 Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 Department of Important: If It any Injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Nother (Specify) Entomb 2-20-2010 Timonium, Maryland Dulaney Valley 21. Signature of Funeral Service 22. Name and Address of Facility Joseph N. Zannino Jr. F.H. Char Conkling St. Baltimore, 23a. Part1. Enter the disease, or con shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-trans Due to (or as a consequence of): Box 68760, certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 MNo Dav 5 Other (specify) sate has been signed by the page 2 should be detached f Ö □Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ∰Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending death. investigation neral Director: / / filled in by the f 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funeral I Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) FEBRUARY, 17,2010 D69198

5 V State Registrar

DHMH 17 Rev 1/2001

9000 Franklin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Linda Ostrowski 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Square Hospital Center Freun Klim

5. Social Security Number 1 mus R If Under 24 Hrs. (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 □ M 2 🖵 F 218-60-5523 Director Feb. 17, 1952 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Medical Everning must be multified at MD N/A Baltimore Director 1 Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4806 Bowland Avenue 21206 USA within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 3 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 SpeciWhite þ If Yes, Give 1 □Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) N/AN/A12th N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nelson Barbara Joseph Ostrowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1917 Stanhope Rd. Balto., MD 21222 Lisa Szymanski 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory 2/19/2010 Hanover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charisse N. Woods F/S 2700 Edmondson Ave. Balto., MD 21223 romarke 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Anoxie prain disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ardiece Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burlal-fransit 2010 05 0 Due to (or as a consequence of): O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐Yes 2 XNo 9 Unknown 9 Unknown ٦. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy of Vital 1 ☐Yes 2 No 1 ☐Yes 2 ☐No Hospital or Attending Physician; completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the and manner stated. 29b. Signature as 29c. License number Hospitalist 29d, Date signed (Month, Day, Year) H0052024 James Welker, Do of person who completed cause of death (Item 23a) (Type, Print) egi trar's Signature ouare Dr James State Registrar

DHMH 17 Rev 1/2001

OSTRUSKI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 13, 2010 Margaret Snoots Powers 9:35 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Holy Cross Hospital Silver Spring Montgomery Social Security Numbe 8. Date of Birth May 2, 1917 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 M 2 X I Director Washington, DC 92 <u>577-01-9615</u> Usual Residence of Decedent 28a-f shov 10a. State 10b County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Ifem 27: is marked outher than "natural", or items 23a or 28a-f sho any injury or or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 😿 No MD Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7845 Alderman Court 21076 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black. White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 x Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Bank Teller Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Francis X. Lansdale Gladys May Annadale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kay P. Riley /daughter Alderman Court, Hanover, Maryland 21076 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1

Burial 2

Cremation 3

Removal from State 4 Donation 5 Other (Specify) W. Arundel Crematory Feb 16, 10 Odenton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. M00773 Annapolis Rd., Odenton, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Atherosclerotic Heart and Vessel Disease Medical Due to (or as a consequence of) Examiner Acute Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) ending physician and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed <u>Ar</u>rhythmia that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death Unknown been signed by the s P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 🔀 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 🔀 Natural 5 Pending iniury 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a, Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) D19924 February 16, 2010

Registrar

1500 Forest Glen Road, Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

Dr. Lawrence Duriero,

18 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death e Druale 5,2010 **Physician** 726 onna nn /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Mary land Social Security Number Hospital

7. Age (In yrs. last birthday, Paltmore General If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 1 ☐ M 2 🗷 F Days 215-64-7699 Director Marylanc Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 ☐ No Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9133 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Tyes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 21215-0036 1 ☐Yes 2 No þ Specify:. 3 ☐ Widowed 4 ☐ Divorced than "natural", Completed Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natur any injury or other traumatic event, the Medical sonce. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Marson tation 18 Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 301/C ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Balto, MD 21221 20c. Location - City or Town, State Nibia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 02/19/2010 Baltimore MD 22. Name and Address of Facility Dernick C. Iones F.H. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown this certificate has been si al director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☑No 24a. Was an autopsy erformed? 1 La Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No ithin 24 hours after death.

• the Funeral Director: A proppletely filled in by the fu 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) finder the Ballmore etha 827 som asheras 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	te of Maryland / Depa <i>Cer</i>	artment of H <i>tificate of D</i>		Mental Hygie Reg	7010	04419		
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)	ry 5 / M			2. Date of Death Month Solution	Day Year	3. Time of Death 700 PM		
	Medic Examin		4a. Facility Name (if not institution, give street and	d number)	4b. City, Town, or	Location of Death		4c_County of Death			
-	Funeral		5. Social Security Number 6. Sex	7. Age (In vrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	nathurz 9 Birth	place (State or Foreign		
	Director		220-18-3488 1□M28	F 84 Yrs.	Months Days	Hours Min.	(Month, Day, Ye	ar) _ Coul	ZY AND		
	show dat	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits		
	e Mary r 28a-f notifie	Director	M.D. BALTIMORE 10e. Street and Number	RAND	AIIS TO	NUN	140	633	1 🗆 Yes 2 No		
	with the s 23a o	Funeral	3412 CARRIAGE	HILL CIRCLE	101. 21p Code	1/33	109	Citizen of What Cou	,		
.	within 72 hours after death with the Maryland grene. er than "natural", or items 23a or 28a-f sho er than Medical Examiner must be notified at	by Fur	11 Marital Status 12 Was	Decedent Ever in U.S. 13. V	Vas Decedent of His FYes, specify Cuban	panic Origin? (Sp , Mexican, Puerto	Specify Yes or No- rto Rican, etc.) 14. Race - American Indian, Black, White, etc.				
0036	urs afte tural", o al Exan	ted b	3 X Widowed 4 ☐ Divorced If Ye Year		Specify: BL	ACK					
215-	n 72 ho an "nat Medic:	Completed	15. Decedent's Education (Specify only highest grade comp Elementary/Seconday (0-12) Colle	leted) (Give k	lent's Usual Occupa kind of work done du O NOT use retired)	tion uring most of work	king 16	b. Kind of Business In	ndustry		
121	d withii dygiene ther th nt, the	a	17. Father's Name (First, Middle, Last)	Libe	ary Aid	40. Martha da Marc	(Elect Added to Adde	Labrary			
lanc	d be file Jental H urked o tic eve	70 E	HARRY BIDDL	É		LEONO	ne (First, Middle, Maid RA R	EID			
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print) Lenora Briscoe / Nico		·			ty or Town, State, Zip	Code)		
			20a. Method of Disposition	20b. Place of Dispos			BA Baltin	c. Location - City or T	own, State		
Baltimore,	Pag ant		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	Governgen For	est VA Cons	ten 03/01	12010 On	ings Mills.	MD 25 FIH, P.A.		
Ba	permit. Departr Import any inji	. 4	21. Signatu of Funeral Service Licentue	C-1 4	. Name and Address	L HGTS.	AVE. BAL	T'MORE,	MARVIAND		
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final		Approxi ate Interval Between Onset and Death						
	Medical	3 77	disease or condition resulting in death)	-	Oliset and Death						
	Examiner	er	Sequentially list conditions, bb	e to for as a consequence of the							
	tuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	e to sur as a consequence of							
0	icate be executed physician and s the burial-transit	edical E	resulting in death) Last Du	e to (or as a consequence of):							
8760	tificate ing phys		IF FEMALE:		-						
Box 687	hat the death certific ed by the attending I detached for use as	Physician/M	23b. Was decedent pregnant 23c. If ye	s, outcome of pregnancy Live Birth 2 Fetal death 3 Pregnant at time of death 5	Ectopic pregnancy Other (specify)	,		23d. Date of deliving Month	very Day Year		
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Division of Vital Records, P.O.	v requires that s been signed t should be det	ed by	Tath. One significant conditions contained	to death but not resulting in the di	nderlying cause give	THIT CITE.		co use contribute to t	bably 4 Unknown		
corc	law req nas bee s 2 shou	Completed					24a. Was an autopsy	prior to co	ppsy findings available ompletion of cause of		
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on of	nding P uth. : After t e funera	cate:	27. Mann f Death 1 Natural 5 Pending 2 Accident Investigation	Date of injury (Month, Day, Year) 28b. Time of injury	28c. Injury work? M 1 1 1	at ′es 2 □ No	28d. Describe how i	njury occurred			
visio	or Atter frer des director in by the	Certificate:	3 Suicide 6 Could not be	Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office		28f. Location (Street City or Town, St	t and Number or Rura tate)	l Route Number,		
۵	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Within 24 hours after death. To the Funerial Director, After this certificate has been signed by the attending it completed filled in by the funeral director, page 2 should be detached for use as	Medical C		the best of my knowledge, death o							
	the Ho	Mec	only one) 3 Certifying Nurse Practic	ledical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) a							
	⊭ತೆ∺ಬ		· ///	"Law	ROSS	2852	- F51	SMAM	162010		
			30. Name and address of person who completed	cause of death (Item 23a) (Type, P	rint)	Tomus?	503 Ka	winds 1	landred 2120		
	Stat Registra		31. Date filed (Month, Day Year) 8 2010	cause of death (Item 23a) (Type, P	ares		a Con	, , , , , , , ,	27-17-5-12-0		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month R 0016 5:00 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 409 BALTIMORE THIAN BALTIMORE 5. Social Security Number Funeral 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🔀 M 2 🗆 F Hours 0 17 1 4 / Director 218-46-9426 61 Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10a. State 10b. County Examiner must be notified at 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 XYes 2 No MD N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 5409 Lothian Road 21212 U.S.A 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. "natural", or þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me lementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Correctional Officer State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be Alvin Mildred Patterson Rooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5409 Lothian Rd, Baltimore, MD 21212 Judy Rooks(Wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 102/17/10 Baltimore, MD Signature of Funeral Service Licensee ²Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final STAGE CHRUNIC OBSTRUCTIVE PULMONARY DISEASE Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death ☐ Other (specify) signed by the a Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe death?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I Yes 2 completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Gertifying Nurse Practiciens To the best of my knowledge d at the time, date and place, and due to th 29b. Signature and title of equilier 29c. License numbe 29d. Date signed (Month, Day, Year) M.D. DS7722 FEBRUARY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FONARD RICHARDSON 1838 GREENE TREE ROAP #300 PILLESVILLE State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Merbruary Pay 10, **20**10 2045 Archie Ramsey Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ★ M 2 □ F Davs Hours 1a (Merth, Dzy) Year) 1928 Al'aBama 81 423-34-4023 **Director** Usual Residence of Decedent t of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No Prince George Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20705 11405 Indigo Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Completed by 1 Never Married 2 Married 1 Yes 2X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 ₺ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Engineering Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Ramsey Rosie Bonner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11405 Indigo Drive Beltsville, MD 20705 Gwendolyn Thomas - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date St. Paul Cemetery or 1 🔀 Burial 2 🗆 Cremation 3 🗔 Removal from State permit. Page Department of Important: If any injury or 2-20-10 Oak Hill, Alabama 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Name and Address of Facility
Hudson Funeral Home
620 W. Commerce St St Greenville, AL Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition resulting in death) Cardiopulmonary Arrest Medical Due to (or as a consequence of) Examiner Acute Chronic Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav 5 Other (specify) Pregnant at time of death 1 Yes 2 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🟝 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending death. 2 Accident
3 Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Praymoner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on e and title of c 29b. Signatu 29c. License numbe 29d. Date signed (Month, Day, Year) D0065069 February 11, 2010

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Signature

1500 Forest Glen Road Silver Spring, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sirak Lemma, M.D.

31. Date filed (Month, Day, Year)

FEB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month February Physician/ 2010 A M 8:15 Craig Albert Rosenberger Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 7896 Pavilion Drive Severn 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 **X** M 2 □ F Months Days Hours Min. (Month, Day, Year) 07-22-1959 Germany Director 50 219-90-5099 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits aţ 10a. State 10c, City, Town or Location within 72 hours after death with the Maryland Director ems 23a or 28a-f sh r must be notified a 1 Yes 2 X No MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 7896 Pavilion Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Examiner Armed Forces? Black, White, etc. 5 þ 1 X Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: "natural" Completed 3 Divorced White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 linand Mental Hygiene.
7 is marked other than "n life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Giant Food Security Guard Be 18. Mother's Name (First, Middle, Maiden Sumame) 17, Father's Name (First, Middle, Last) မှ Elizabeth A. Hopstein Albert S. Rosenberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 10711 Jordan Road Argenta, Illinois 62501 Sheryl E. DeBose / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland 102-16-2010 Crematory 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.

Donaldson Funeral Home & Crematory, P.A.

11-2 Pool Odenton, Maryland 21113 Funeral Servi Licen e Rent 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final -OROHARY Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Dish to for as a numeric rence of: cause (Disease or iinjury that initiated events requires that the death certificate be executed and -trans resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death the Unknown 9 Unknown as been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Records, Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an End Stage Renal Disease has page 2 autopsy performed? 24 hours ar er decth. • Funeral Director: After this certificate heted filled ⊨ by the funeral director, page 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Tyes 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled by determined Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 To the I only one) 29c. License numbe 29b. Signature and till

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Raphael Dodoo, MD

FEB 1820

31. Date filed (Month, Day, Year)

D57787

1916 Crain Highway Suite 7, Glen Burnie, Maryland 21061

February 09, 2010

VOID

CERTIFICATE

-2009 2010 - 04423

SEE

CERTIFICATE #

2009-43668

Amend #30 per byR G900 2/18/10 TT State of Maryland / Department of Health and Mental Hygiene [for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2270 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cit₩ 4c. County of Death fown, or Location of Death Examiner STOWN 24 Hrs. 8. Date of Birth Min. (Month, Day MANDAL CONTER BALTIMONE 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Funeral 1 □ M 2 1 F Months Days Hours Director 054-10-2174 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Exertiner must be notified at Director WOODLAWN 1 ☐ Yes 2 🕱 No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ់ USA 2017 GREENGAGE ROAD 21244 or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No WHITE Specify ð Specify: 3 X Widowed 4 □ Divorced 'natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. filed within Hygiene. College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **JACOB** LACHER DORA BRAFF မ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health are Important: If item 27 is any Injury or other trausonce. WOODLAWN, MD 21244 RITA ROTHENBERG/DAUGHTER 2017 GREENGAGE ROAD, 20b. Place of Disposition (Name of OHR KNESSETH TSRAEL ANSHE KOLK 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/17/2010 |BALTIMORE. MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending physi Box IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for P.0. 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform this certificate Vital 1 ☐ Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA ot funeral Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? or Attending After Division 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randolph Nicholas Brown, MD Northwest Hospital Center Randallstown, MD 32. Regi (rar's Signature 31. Date filed (Month, Day, Year) State Registrar

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	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Director	10a. State ND BALTIMOI	RE	10c. City, T	Town or Loc						10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
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Baltimore, Maryland 21215-0036	permit. Page 1 ar Department of He Important: If iter any injury or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		20b. Plac Cerr MFMOR	ce of Dispos Detery, crem B SH/	sition (Name of patory or other p DARK	olace) 02/1	Date 7/2010	20c. Locati	•	Town, State	
Balt	21. Signature of F leral Service Licensee 22. Name and Address of FacilitySOL LEVINSON & BROS									ROS.,	INC.		
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. Box 68760	Attending Physician: The law requires that the death certificate be ar death are strongly and actor. After this certificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live Birth 2 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal d	eath 3 🗆	Ectopic pregn Other (specify,			23d	l. Date of de Month	elivery Day Year	
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tai	sician: The certificate I rector, page	Be	25. Was case referred to medical examiner?	Hospital:				Place of Death (Che		-		Home	
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	e Hospi 24 hou e Funer leted fill	Medical	(Check 2 Medical Exam	sician: To the best of r iner: On the basis of ex se Practioner: To the b	amination ar	nd/or invest	igation, in my op	inion, death occurred	at the time, date	and place, and	d due to the	cause(s) and manner stated.	
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			30. Name and address of person who	completed cause of de	of th (Item 23	3a) (Type, P	rint) 0	Ed Con	et Ac	1; Day	(L'mi	n, Do Will	
	Sta Registra		31. Date filed (Month, Day, Year)	37. Registra	r's Signature	ba	Kel						

DHMH 17 Rev 7/2009

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Amend #5 tate of Maryland / Department of Health and Mental Hygiene 04426 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY MARVIN JOSEPH SCHMITZ 2010 10:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death NATIONAL INSTITUTES OF HEALTH BETHESDA MONTGOMERY 5. Social Security Number 8. Date of Birth (Month, Day, Ye Aug. 13, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Year) Maryville, MO 489-60-1957 Director 52 1957 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits with the Maryland Director 1 Yes 2 No Missouri Taney Kissee Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 325 Lakeway Road 65680 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Owner/Operator Service Station Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Joseph Schmitz Joanne Pitzenberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carla Schmitz (Wife) 325 Lakeway Rd., Kissee Mills, MO 65680 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 2 - 23 - 10St. Joseph Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Parnell, MO 22. Name and Address of Facility
Price Funeral Home
120 E. First St., Maryville, MO 64468 Signature of Funeral Service Licensee 23a Part / Ent ir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirtly, or reart failure. List only one cause on each line. Approximate Interval Between Immariate Cause (Final Onset and Death Septic SNOCK Physician/ 9 days disease or condition Medical resulting in death) Examiner 6 years EMONOMA CUIDA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Month Year Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

Yes 2 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Matural injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 16,10 00069249 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RACHEL GREENBERG 10 CENTER DRIVE. BETHESDA, MARYLAND 31. Date filed (Month, Day, Year)

State

Registrar

FEB 18 2010

32. Registrar's Signature

State of Maryland Department of Medital Hygiene 20 10 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February sanders unk M Medical Facility Name (if not institution, give street and number) City, Town, or Location of Death County of Death Examiner KattiMore Yursina 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** Min. 1 ⊠ M 2 □ F Director Usual Residence of Decedent 10b. County City, Town or Location 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at **Funeral Director** 1 🗆 Yes 2 🔀 No naton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20017 USA 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married δ Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give 3 Widowed 4 Divorced Completed Year or Dates. event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. nday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last and Mental | Health a permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount 21. Signatu e of Funeral Service License 2/2/2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hupernat remia disease or condition resulting in death) Medical Due to lo as a consequence of): Examiner contraction Volume Sequentially list conditions. Examine rany, leading to infinitediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Asbiration To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the itnerial director, page 2 should be detached for use as the burial-transit pneumoni that initiated events Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by anemia 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? throm boay tupenia 24a. Was an autopsy diseas performed' liver 2 🗆 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🛮 Natural 5 Pending Investigation
6 Could not be 1 🗌 Yes 2 🗌 No 2 Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a Certifier 1 Z Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0005896 Jain February 15th 2010 besty 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KHAWAS 21133 32. Registrar's Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 4, 11:00 PM Rogers Stevenson Feb. 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Silver Spring Genesis Eldercare Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 X M 2 □ F 56 Director 241-88-0937 North Carolina Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Mudical Expiniter must be notified at Director 1 ☐ Yes 2 → No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3227 Bel Pre Road 20906 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 ☒ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. <u>ş</u> Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Truck Driver Transportation 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be 18. Mother's Name (First, Middle, Maiden Surname) Marvin Stevenson, Sr. ဂ္ Mildred Sims 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Sister) Josephine Zollicoffer 261 Coley Spring School Rd., Warrenton, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Greenwood Church Cem 2/13/2010 Warrenton, NC 4 ☐ Dopation 5 ☐ Other (Specify) 21. Sign rure of Fineral Service Licensee 22. Name and Address of Facility
Boyd's Funeral Service P.O. Box 31, Warrenton, NC 27589 Winn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cancer **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate caus. Enter of milion Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate perform 1 ☐ Yes 2 X No 1 ☐Yes 2 ☐No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide e Funeral I 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00064208 2/15/10 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pre Road, 3227 Saadia 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 16, 6:40 P M Showalter 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Severna Park Severna Park Anne Arundel Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours Min July 29,1920 Washington, D.C. 89 579-20-7624 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 🗌 Yes 2 😾 No MD Anne Arundel Co. Pasadena 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 United States 306 Goldenrod Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc er than "natural", or the Medical Examin þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 9 yrs. Bindery Worker Binderv Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be file alth and Mental I 27 is marked o ည Vasilo Valtos William Dagress 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shr Department of Health an Important: If item 27 is any injury or other trau once. Mrs. Catherine T. Puckett/Daughter 306 Goldenrod Dr. Pasadena, Maryland 20a. Method of Disposition
1 ⊞ Burial 2 □ Cremation 3 □ Removal from State 20h Place of Disposition (Name of 20c. Location - City or Town, State Glen Haven Mem. Park 02/25/2010 | Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services PA; 1 2nd Ave. SW; Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final CARDIOVAS EN LAM Physician ARTERIOSCI BROTLE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) signed by the a ld be detached for 1 ☐ Yes 2 ☐ Unknown a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 tonknown Division of Vital Records, SERVIE DISORDER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 1 Yes 2 ANO Yes Hospital or Attending Physician: 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Hospita 1 ☐ Yes 2 ☑ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of n 24 hours after death.

e Funeral Director, After the leted filled in by the funeral 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pendina Work: 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one) 29b. Signature and title of certifier 29c. License number

[Û V | State

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SULY A SULY B 300(

31. Date filed (Month, Pay_Year)

32. Registrar's Signature

21776

ABRUARY 17, 2010

HAROVER ST. BALTIMORE ND

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1 Decede 's Name (First, Middle, Last) **Physician** 20/0 e /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown 3415 Meadowdale Drive If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) Days Hours Months 1 □ M 2 💢 F March14,1935NorthCarolina Director 74 237-52-0828 Usual Residence of Decedent death with the Maryland 10d, Inside City Limits 10b. County 10c. City, Town or Location show 10a. State ?7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be molified at 1 ☐ Yes 2X No Director Maryland Baltimore Randallstown 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21244 3415 Meadowdale Drive Funeral S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 XNo ģ Specify:Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be 1 and 2 should be Health and Mental Amanda Cherry Thurston Jones ပ Health and Nem 27 is mai 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 19a. Informant's Name/Relationship (Type. Print) 3415 Meadowdale Drive,Randallstown,Maryland permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr Linda Spruill Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2-13-10 Williamston, N.C. Smith Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Marzullo Funeral Chapel, P. A. michael 6009Harford Road, Baltimore, Maryland21214 Nulley 11 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** revos disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the asn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) □Yes 2□No the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 5 24 hours a Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated the within 7 29b. Signature and tile ne and address of person who comp filed (Month, Day, Year, State 18 Registrar

DHMH 17 Rev 1/2001

			For State	State of Ma	aryland		artment of H		and Me	ental Hy	giene	2010	04431	
			Registrar 1. Decedent's Name (First, Middle, Last	·)		Cer	uncale of L	<i>Jeann</i>		2. Date of De	Reg. No.	2010	3. Time of Death	
	Physicia Media		Narmadaben	Thanki						Month Februa	Dav	6, 2010		
	Examir		4a. Facility Name (if not institution, give				4b. City, Town, or	Location	of Death	100100		4c. County of Death		
			Holy Cross Hospita						Spring		Montgomery			
	Funeral Director		5. Social Security Number 6. Se	x	(In yrs. last	t birthday) Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Birt Months Days Hours Min. 05-18-1					Cou	nplace (State or Foreign	
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land	ntr. Page 1 and 2 should be filed within 72 hours after death with the Maryland artificant of Health and Mental Hygiene. Artification of Health and Mental Hygiene. Or artification if them 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at.	호	10a. State 10b. County		10c. City,	Town or Loc	ation						10d. Inside City Limits	
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030 rs aft	raľ, Exar	ed b	3 🗌 Widowed 4 🗌 Divorced	If Yes, Give Year or Dates.	10	1	☐ Yes 2 X No	Specify	<i>'</i> :		8	Specify: Asia	n Indian	
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an B B B	rked or	힡	Arjumlal Modha						,	en Tha		ourname)		
ary hould	f Health and Mental Hygien Item 27 is marked other tl other traumatic event, the		19a. Informant's Name/Relationship (Ty)	oe, Print)		19b. Mailin	g Address (Street a					Town, State, Zip	Code)	
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ore e 1 ar	i of He		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Removal from State			sition (Name of atory or other place	e)	Da	te	20c. Lo	cation - City or	Town, State	
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Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after	Department of Healt Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Coense	0/1	1)	22	Name and Addres	s of Facili	ity nera1	Home 8	Cre	matory.	Р.А.	
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			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	ine deain. i	DO NOT EINE	r the mode of dying	y, such as	cardiac or r	espiratory arr	est,		Approximate Interval Between Onset and Death	
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Division of Vital Records, talor Attending Physician: The law requires	r this eral di	2 등	27. Manner of Death	1 X Inpatien 28a. Date of injury	28	₹/Outpatient Bb. Time of	3 DOA 28c. Injury	4 ∐ Nı		5 Resid		Other (Specif	y)	
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fal C	irs aff al Dir led in			building, etc.	(ареспу)				- 4	City or Tow	n, State)			
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the	thin 2 the l omple		only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practioner: To the be	est of my kr	nowledge, d	eath occurred at the 29c. License	time, date	e and place, a	and due to the	cause(s)	and manner as s	tated.	
P 2	ĕ ¥ ĕ			10	DO					1		signed (Month,		
	0		30. Name and address of person who co	mpleted cause of dea	ath (Item 23	Ba) (Type: Pr	H006	4588			Feb	oruary 1	7, 2010	
	21			1500 Fores	,	, , , , .	,	Snr	ina 1	/arv1 a-	A 20	1010		
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	Registra	ar	FEB 1820	10 farma	- A	· FR	and							

Physician	/
Medica	ı
Examine	r

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland

Division of Vital Records, P.O. Box 68760

	for State	State of Maryl	-	artment of H rtificate of D		-	21	010	04432
	Registrar 1. Decedent's Name (First, Middle, La	st)	Ce	runcate or D	eaui	2. Date of De	Reg. No.		3. Time of Death
Physician/ Medical	Margie Frances	Teasley				Month Februa	Dav	Year 2010	6:10 p M
Examiner	4a. Facility Name (if not institution, give	e street and number)		4b. City, Town, or I	ocation of Death			ty of Deatl	
	Patuxent River He			Laurel	K. 1 0411			ce Ge	
Funeral Director	5. Social Security Number 6. S 228-46-8542	Sex / Age (In y. I ☐ M 2 ဩ F	rs. last birthday) 79 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da Feb. 13	ay, Year) 9. Bi		hplace (State or Foreign untry) VA
L tow	Usual Residence of Decedent 10a. State 10b. County	100	City, Town or La	ocation					10d. Inside City Limits
or 28a-f she notified at Director	MD Prince (urel	oution					1 ¥ Yes 2 □ No
or 28 e noti	10e. Street and Number	seorge Ina	urer	10f. Zip Code			10g. Citizen o	f What Co	
er must be Funeral	14200 Laurel Par	o Drive		20707			USA	I.	
or amin	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give		Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 🛣 No	, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ack, White	rican Indian, e, etc. 11te
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Hygier other tent, the	9 17. Father's Name (First, Middle, Last)		Apar	tment Mana		o Eirot Middle	Resid		11
rked o	17. Father's Name (First, Middle, Last) Unknown Harris Unknown Unknown								
and M is mai	19a. Informant's Name/Relationship (Type, Print) Grand-	19b. Maili	ing Address (Street ar	nd Number or Run	al Route Numbe	er, City or Town,	State, Zip	Code) 20724
m 27 in earth and the	Kimberly A. Kings			Corridor	Market F	lace,Su	uite 40	0-57,	Laurel,MD
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Depart Import any inj once.	21. Signature of Funeral Service Licer			2. Name and Address 13 Talbott					ne, P.A.
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within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completed filled in by the funeral director, page 2 should be detached for use as Medical Certificate: To Be Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date Mon								ivery Day Year
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cate has been sip page 2 should t	Diabetes Mellitu Stage IV Decubit					24a. Was auto perfo 1 Yes		prior to death?	copsy findings available completion of cause of 2 🔀 No
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To CO	29b. Signature and title of our tifier	A Was	nea	29c, License i	13911	0	29d. Date sign	·	
) \	30. Name and address of person who Dr. William A. Wa	·		•	t., Laur	el,MD 2			
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Sig		del					

DHMH 17 Rev 7/2009

10-00979 Damon Wilt

OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 04433

	1- For State Registrar		Certificate	of Death		R	eg. No.		
Physician Medical Examine		Wilt				2. Date of Dea Month February	Day Year	3. Time of Death 0148 hrs	
	4a. Facility Name (if not institution University Hospital	on, give street and number)		4b. City, Town, o Baltimore	or Location o	of Death	4c. County of Death N / A		
Funeral Director	5. Social Security Number Unknown 218-92-7175 Usual Residence of Decedent	1XM 2F	n yrs. last birthday)	If Under 1 Ye Months Da			th(MM/DD/YYYY) 9. Bir 10, 1978 ^{co}	thplace (State or Foreign untry)	
ne Maryland or 28a-f show any fired at once.	10a. State 10b. County MD	N/A	c. City, Town or Lo Baltimo	ore				10d. Inside City Limits 1 X Yes 2 No	
the Maryland as or 28s-f shortified at once	10e. Street and Number 5601 Fords	Ln. # 508		10f. Zip Code 212	215	1	0g. Citizen of What Cou USA	ntry?	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. Important: If item 27 is marked other than "natural", or items 23a or 28s-f sho injury or other traumantic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	3 Widowed 4 Biv	arried 12. Was Decedent Ev Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	No 1		an, Mexican, lo <i>specify:</i>	gin? (Specify Yes or No , Puerto Rican, etc.)	14. Race - Ameri White, etc. Specify: Whi		
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12)	College (1-4 or 5+) N/A	during	most of working lif	fe. DO NOT	use retired)	N/A	industry	
AD 21215-0036 2 should be filed within h and Mental Hygiene. 27 is marked other tha matic event, the Medic To Be Compl	Terry	Wilt			Lil		vart		
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medisa To Be Comble	Terry Wilt/F		5601	Fords	Ln #		nber, City or Town, State		
Baltimore, ME permit Pages I and 2 s permit Pages I and 2 s permit of Health an Important: If item 27 injury or other traums	20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other Sp	pecify:	Ardent	Cremato	ory		20c. Location - City or Hanover,	MD	
Balt permit. Depart Impor	21. Signature of Funeral Service	Frenule	1 2	2700 Edr	nonds	on Ave. E	Cromart Balto., MI	21223	
Physician /Medical Examiner	23a Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. a. Fentany1 I	ntoxicati		g, such as ca	ardiac or respiratory arm	est, shock, or heart	Approximate Interval Between Onset and Death	
-	Sequentially list conditions,	b. Due to (or as a consequ							
red Insit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence)					, , , , , , , , , , , , , , , , , , ,		
execuran and an and al - tra		d. x AMENDED 5 pe	r fh ,23a	,27,28a-	f per	me g901 3	-22-10 vt		
Box 68760, e death certificate be exe the attending physician a ed for use as the burial - hysician/Medica	2 Sectopic pregnant in the past 12 months? Live birth Pregnant at time of death Other (Specify) Month								
P.O. Be res that the de signed by the be detached if		ions contributing to death bu	it not resulting in the	e underlying cause	given in Pa		bacco use contribute to		
cords aw requi has been 2 should						24a. Was a autop perfor	sy prior to c med? death?	topsy findings available completion of cause of	
Vital Rec ysician: The l his certificate I director, page o Be Corr	25. Was case referred to medical examiner?				TOthor:	Check only one)			
on of Vi tending Physi auth. or: After this the funeral di		28a. Date of Injury (Month, Day, Year)	2 PR/Outpatie	f Injury 28c. Inj	ury at Work	? 28d. Describe h	Residence 6 Other now injury occurred	:	
Division ospital or Attending hours after death. neral Director: After filled in by the func	2 Accident Inves 3 Suicide 6 X Could 4 Homicide deter	d not be 28e. Place of Injury	- At home, farm, st	reet, factory, office	building, etc	or Town, S	Street and Number or Rultate) 201 W Free Md. 212	ral Route Number, City ranklin St. 01	
To the Hos within 24 h To the Fun completely		nysician: To the best of my kn miner:On the basis of examina and manner stated.							
ع المارة	29b. Signature and title of certifie	1114			.M.E.		29d. Date signed (Mor February 3, 2010	· •	
<i>X</i> 0√	30. Name and address of person Zabiullah Ali, M.D.	who completed cause of death Assistant Medical Exan		enn Street, Bal	Itimore, M	4D 21201		***	
State Registrar	62 May 10 10 10 10 10 10 10 10 10 10 10 10 10	32. Pegistrar's S	Signature	4					
DHMH 17 Rev 1/2001	12018	CUIU / Chresina	ORIGIN	AL			OCME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February **Physician** Gladys 13, 2010 Williams 7:26 PMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHARLES COUNTY NURSING & REHAB LA PLATA CHARLES 8. Date of Birth (Month, Day, Year March 26, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Days Hours Year) Min. 1 □ M 2 🛛 F 87 Director 1922 Georgia 265-20-1956 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director 1 Yes 2 □ No Florida Pinellas Clearwater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a 1435 Mission Drive West 33756 U.S.A. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No Specify. Specify: Black ð 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, II* II* Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk Medica1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pasco Foster မ Ruth Ginlock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Williams (Son) 7614 Wind River Dr., Sylvania, OH 43560 20b. Place of Disposition (Name of Sylvan Charlety, Company or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 2/20/2010 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park Clearwater, FL 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility
Young's Funeral Home, Inc. 1005 Howard St., Clearwater, annes mur 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) hoonic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Dus to for as a consequence of or Attending Physician: The law requires that the death certificate be executed and use as the burial-trar resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the huria IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death? this certificate has al director, page 2 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 □Yes 2 □No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Comparison of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date; signed (Month, Day, Year) 55455 woon) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Hussein, M.D.

DHMH 17 Rev 1/2001

32. Registrar's Signature

445 Defense Highway, Annapolis, MD 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 04435 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Albert Watford 1051AM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico 9. Birthplace (State or Foreign Country) Maryland If Under 24 Hrs. **Funeral** 8. Date of Birth 1 🕅 M 2 🗆 F (Month, Day, Y ept 6, **Director** 81 Sept 223-32-1978 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1013 Queen Avenue 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: black Specify: 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) truck driver transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Wallace Watford Della Stewart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1013 Queen Avenue Salisbury, MD 21801 19a. Informant's Name/Relationship (Type, Print) Shirley Watford/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) gnature of Euneral Serv State Anatomy Board 655 W. Baltimore Street Baltimore MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ COLON MALIGNANT CARCINDMA disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or iinjury Examine Due to jor as a consecuence of Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and that initiated events Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant Unknown 5
Other (specify) Month Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate 2 AN Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2. 1 No Other: 4 Nursing Home 5 Residence of Other (Specify) HOSPICA 1 Tyes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO05 8410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21807 1733 Stry Buch 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Contificate of Death

Reg. No. 2 0 04436

_			- Registrar			timouto or E		B	eg. No.	0	
	Physicia		1. Decedent's Name (First, Middle, The 1ma	Louise	W	alters		2. Date of Deat Februar	ь y ^{Day} 7, 2 01 0	3. Time of Death 12:50A M	
	Medic Examin		4a. Facility Name (if not institution, of Heart Homes of	·		4b. City, Town, or Linthic	Location of Death		4c. County of Deat		
Ī	Funeral Director			S. Sex 7. Age (In yrs.	last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth June 13	Year)	thplace (State or Foreign untry) nsv1vania	
	yland •f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County		ity, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
	he Ma or 28a t notifi	Funeral Director	MD Anne 10e. Street and Number	Arundel Co.	OTCH D	10f, Zip Code		1	Og. Citizen of What Co		
	with t	eral	404 2nd Avenue SW 21061 United S								
36	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at		11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	If Yes, Give		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 💢 No	n, Mexican, Puerto	14. Race - Ame Black, White Specify:	e, etc.		
3	hours natura ical E	letec	15. Decedent			dent's Usual Occup		1	16b. Kind of Business	nite Industry	
Baitimore, Maryland 21215-0036	within 72 giene. er than "r , the Med	Completed by	(Specify only highest Elementary/Seconday (0-12)	College (1-4 or 5+)	life. D	kind of work done o O NOT use retired) omemaker		ing	Own Home		
and	be filed ental Hyg ked oth c event	To Be	17. Father's Name (First, Middle, La William S. H	art				ne (First, Middle, N ietta (daiden Surname)		
aZ	1 and 2 should be file if Health and Mental I item 27 is marked o other traumatic eve		19a. Informant's Name/Relationship		19b. Mailii	ng Address (Street			City or Town, State, Zip	Code)	
Σ,	1 and 2 s of Health item 27 i		Mrs. Jacqueline			2nd Avenu	e SW G1				
201	0		20a. Method of Disposition 1 Burial 2 Cremation	B ☐ Removal from State	osition (Name of matory or other place Cremator			20c. Location - City or	,		
	permit. Page Department Important: Il any injury or once.		4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service Lic			8/2010 ngleton	ie, MD Cremation				
ñ	Der any) u.Q	M011	.21 S	ervices,	PA; 1 2nd	d Ave SW	; Glen Burn	nie,MD 21061	
- 4	Physician Medical		23a. Part 1. Enter the disease, or c shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ly one cause on each linea	twe f	the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death	
	Examiner	L	Sequentially list conditions,	Due to (or as consect	quence of):					/	
	ted I nsit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	Due to (or eale consec	quence offi						
	certificate be executed nding physician and use as the burial-transit	sal Exa	that initiated events resulting in death) Last	Due to (or as a consec	quence of):						
09/89	ificate I ig phys as the	an/Medical	IS SERVICE.	d							
	v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	ey 		23d. Date of de Month	23d. Date of delivery Month Day Year			
т. О	s that thigned by	þ	Part II. Other significant condition	s contributing to death but not re	esulting in the u	underlying cause gi	ven in Part I.		pacco use contribute to		
Space	require been s should	eted						24a. Was ar		robably 4 Unknown topsy findings available	
or vital Records,	The law	Completed						autops perform	med? prior to death?	completion of cause of	
Ital	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	7	Oth	ace of Death (Chec			ity Astiskellion	
on or v	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for	icate: To	27. Mann of Death 1 Natural 5 Pending 2 Accident Investiga		28b. Time of injury	f 28c. Injur	4 □ Nursing H	ome 5 ∟ Reside 28d. Describe ho	nce_6 ☑ Other (Spec w injury occurred	ity) AJ SA SPEZILLOT	
DIVISION	tal or Atters after destal Directored in by the	l Certificate:	3 Suicide 6 Could not determine			eet, factory, office		28f. Location (Str City or Town	reet and Number or Ru. , State)	ral Route Number,	
	he Hospit in 24 hour he Funera pleted fill	Medical	(Check 2 Medical Ex	Physician: To the best of my know aminer: On the basis of examination Nurse Practioner: To the best of n	on and/or inves	tigation, in my opinio	on, death occurred a	at the time, date an	d place, and due to the	cause(s) and manner stated.	
	To t With		29b. Signature and the of certifier	Sold		29c, License	e number D2009 Y	2	9d. Date signed (Month	n, Day, Year)	
	6 1		30. Name and address of person w	ho completed cause of death (Itel	m 23a) (Type, F	Madua	Park	Drive, C	la burnit	, md, 21061	
	Stat Registra	te ar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	are)		r		,	
					6163						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Healthand Mental-Hydiene

4		1 - State Amend Items 24a,25,26,27,29a,3	o" per dr., g900;02/ ertificate of Death	18/2010df Reg	No. 2010 04437		
Physic	cian/	1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death		
Me Exan	dical	Thomas R. Wilson 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	(9)	4c. County of Death		
LAdii	mici	11608 Poplar Avenue	Cumberland		Allegany		
Funer		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	Birthplace (State or Foreign Country)		
Directo	or	218-64-8099 1 M M 2 L F 56 Yrs. Usual Residence of Decedent	Mishing Sayo House Hims	Jan 23,	1954 Maryland		
and show at	١		ocation		10d. Inside City Limits		
Aaryla Ba-f s tified	je c	MD Allegany Cumb	erland		1 ☐ Yes 2 😾 No		
the N	٥	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?		
h with	Funeral Director	11608 Poplar Avenue	21502		USA		
deat riten inern	T.		cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.			
affer al", o	d by		1 ☐ Yes 2 💢 No Specify:		Specify: white		
5-UUSO 2 hours after "natural", o dical Exam	Completed	15. Decedent's Education 16a. Dece	16	b. Kind of Business Industry			
Z I Z Lin 72 le. han "	l E	(Specify only highest grade completed) (Give Elementary/Seconday (0-12) College (1-4 or 5+)	·				
d with dygier ther t	Be			oving & storage co			
be filed ental Hy ked ott	P		e (First, Middle, Maid Elise Coy				
aryl ould loud Ind Me			ling Address (Street and Number or Rura		··· — ,		
y Michael Patthau m 27 is			608 Poplar Avenue	Cumberlan	d, MD 21502		
Datumore, Interpretable 21213-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)	osition (Name of Ematory or other place)	Pate 20	c. Location - City or Town, State		
permit. Page Department of Important: If any injury or	ouce.	21. Signature of Funeral Service Licensee Ronald S. Wade, Wirector	Baltimore Street				
		23a. Part I. Enter the disease, if complications that caused the death. Do not en shoot or heart failure. List only one cause on each line.	Baltimore , MD 2120 ter the mode of dying, such as q ardiac o		Approximate		
Physician	v.	Immediate Cause (Final disease or condition	the Francha		Interval Between Onset and Death		
Medica Examine		resulting in death) a. Due to (or as a consequence of):	250/210	3	2.76 ()		
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):	-				
cuted nd ransit	Examiner	Cause (Disease or iinjury that initiated events c					
ficate be executed g physician and as the burial-transit	ia E	resulting in death) Last Due to (or as a consequence of):					
cate to phys	Medical I	d					
	Z/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3	□ F-4'-		23d. Date of delivery		
death ne atte	Physician/N	in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	Country Other (specify)		Month Day Year		
that the dealed by the a	Ph/y	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	Underlying cause given in Part I	00- Dida-b	co use contribute to the cause of death?		
o, r	d b		and anything season great min are n		2 No 3 Probably 4 Unknown		
requires been sign	Completed			24a. Was an	24b. Were autopsy findings available		
he law te has age 2	E O			autopsy performed 1 \sum Yes 2 \bold X	prior to completion of cause of		
an: Tl an: Tl tiffical tor, pi	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check		No 1 Yes 2 No		
hysician: The lar his certificate ha	10E	Hospital: 1 Yes 2 No	ent 3 DOA Other:	me 5 X Residence	e 6 Other (Specify)		
g P P ert		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) (Month, Day, Year)	,	8d. Describe how in			
I or Attendin after death. Director: Aft	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		28f. Location (Street City or Town, St	t and Number or Rural Route Number, late)		
To the Hospital or Att. Within 24 hours after de To the Funeral Direct completed filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, and	I due to the cause(s	s) and manner as stated.		
the Ho hin 24 the Fu npleter	Medical	(Check 2 L. Medical Examiner: On the basis of examination and/or inve	stigation, in my opinion, death occurred at	the time date and ol	ace and due to the cause(s) and manner stated		
Nation of Solid		29b. Signature and title of certifier	29c. License number D 0 0 664	39 29d.	Date signed (Month, Day, Year)		
		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	1			
		Blanche Harry Mavromatis, MD, West 31. Date filed (Month, Day, Year) 32. Distrar's Signature		Jystellis	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
St Regis	tate trar	31. Date filed (Month, Day, Year) 32. rigistrar's Signature FEB 1 8 2010	barker				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			partment of Health and Nertificate of Death		ene 3. No. 2010 04438
Physic	rian/	1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
Med	dical	Helen Catherine Wennell 4a. Facility Name (if not institution, give street and number)	1	Feb.	1 ^{4y} 20 ⁴ 10 9:10 am
Exam	ııner	Carroll Hospital Center	4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll
Funer Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 1 1 M 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Months Days Hours Min.	8. Date of Birth (Month, Day, Yo June 1	9. Birthplace (State or Foreign Country) 2, 1943 Penn.
and show at	٦	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits
Maryle 28a-f otified	rect	Maryland Carroll Manche	ster		1 🗆 Yes 2 🗓 No
ith the 3a or it be n	alD	10e. Street and Number 3817 Millers Station Rd.	10f. Zip Code 21102	10	g. Citizen of What Country? U.S.A.
eath w tems 2	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - American Indian,
Baltimore, Maryland 21213-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	۾	1 Never Married 2 Married 1 No	If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	Rican, etc.)	Black, White, etc. Specify: White
215-0036 hin 72 hours after hen "natural", o Medical Exam	Completed	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16	6b. Kind of Business Industry
hin 72 ne. than "r		(Specify only highest grade completed) (Giv Elementary/Seconday (0-12) College (1-4 or 5+)	e kind of work done during most of work DO NOT use retired)	ng	- '
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Maryland 21 2 should be filed with and Mental Hygier 27 is marked other traumatic event, the			iling Address (Street and Number or Rura		21102
re, M land 2 s Health Item 27 other tra		John R. Wennell, Jrhusband 3 20a. Method of Disposition 20b. Place of Disposition			. Manchester, MD. Oc. Location - City or Town, State
Page 1	1		ematory or other place) s Ch. Cem. Feb.		
Baltimore, permit. Page 1 and Department of Hea Important: If item	ouce.	21. Signature of Fyneral Service Licensee	22. Name and Address of Facility E.C.	khardt i	Funeral Chapel P.A
		23a. Part 1. Enter the disease, or complications that caused the death. Do not en	296 Charmil Dr.	Manche	ster, MD. 21102
Physician	17	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Α	ease	Interval Between Onset and Death
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BOX 08 death certifi he attending	Physician/M	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3			23d. Date of delivery
. bd . the at ched for	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	☐ Other (specify)		. Month Day Year
s that the	by Pl	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
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VItal Kecords, ysician: The law requires is certificate has been sig director, page 2 should b	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
an: Th	Be Co	25. Was case referred to medical examiner?	26. Place of Death (Check		No 1 Tyes 2 No
hysici physici this ce al direc	은	1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpati	-/ 1		ce 6 Other (Specify)
offing Father: After	cate	27. Manner of Death Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) 28b. Time injury	of 28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred
DIVISION OT tal or Attending PP 's after death. al Director. After the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		28f. Location (Stree City or Town, S	et and Number or Rural Route Number,
DIVISION Of VITAI RECORDS, P.O. BOX 05 to the Hospital or Attending Physician; The law requires that the death oertific within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 certifying Physician: To the best of my knowledge, death	a accuract at the time date and place on		N
he Hos in 24 h he Fun pleted	Medical	(Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge death	estigation, in my opinion, death occurred at	the time, date and p	place, and due to the cause(s) and manner stated.
To the		29b. Signature and title of certifier Aunswired (MO)	29c. License number		. Date signed (Month, Day, Year)
10		30. Name and address of person who completed cause of death (Item_23a) (Type	D 5 1705		2-14-2010
N		M. PANSURIYA 349 Mal	colm DR, a	ntest re	inster MOQUIS7
Si	tate	31. Date filed (Month, Day, Year) 32. Registrary, Signature	1		

DHMH 17 Rev 7/2009

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			1 - For State of Maryl Registrar		ertificate of L			ene 201	0 04439
	Physicia	an/	Decedent's Name (First, Middle, Last) Erma Eileen Weide				2. Date of Death Month	n Dav Ye	3. Time of Death
	Medi Examir	cal	4a. Facility Name (if not institution, give street and number)		4. O'. T	al a alla a d Daath	Februa	ry 15,2	010 8:17 A. M
-	/ Examin	ier	3105 Moores Road		Baldwi	r Location of Death		4c. County of D	W.
	Funeral		5. Social Security Number 6. Sex 7. Age (in y	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9.	Birthplace (State or Foreign
	Director		510-22-4866 1 ☐ M 2 🕅 F Usual Residence of Decedent	82. Yrs.	Months Days	Hours Min.	Jan 25	,1928	Kansas
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	tor		City, Town or L	ocation				10d. Inside City Limits
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	th the		10e. Street and Number		10f. Zip Code		10	0g. Citizen of Wha	t Country?
	tth wif	Funeral	3105 Moores Road		21013			S.A.	
(0	or ite	by Fu	11. Marital Status 12. Was Decedent Ever in Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 27 □ No	10.5.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto F	city Yes or No- Rican, etc.)		American Indian, Vhite, etc.
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lan.	shoul and I is ma		19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street a				, Zip Code)
6	and 2 lealth		Claudia Carlson		Moores F	Road, Bal	dwin,Ma	aryland	21013
סר	ige 1 and the first of the firs		1 🗆 Burial 2 🗆 Cremation 3 🗀 Removal from State	 b. Place of Disp cemetery, cre 	osition (Name of matory or other plac	e) D	1	0c. Location - City	
Baltimore,	artme artme ortani injury		4 ▼ Donation 5 □ Other (Specify) □ 21. Signature of Funeral Service Licensee		est Anat			Vhiteha.	
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XO	ath ce attend for us	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Live Birth 2 ☐ time 4 ☐ Pregnant at time	etal death 3	Ctopic pregnancy Other (specify)	у		23d. Date of Month	delivery Day Year
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Division of Vital Records,	or Affer de lirectour by the properties of the p	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At building, etc. (Spe		eet, factory, office	2	8f. Location (Stre City or Town,		Rural Route Number,
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; 	With the		29b. Signature and title of certifier		29c. License			d. Date signed (Mo	
		1	I I varmous tens	NY	103	8950		2/15/	2010
		-	30. Name and address of person who completed cause of death (If MANUEZ V. RAMOS, MD 1204	5 40R	K-RD1	+36,L	UTHER	VILLE,	mD 21093
	Stat Registra	G	31. Date filed (Month, Day, Year) 32. Registrar's Sig	nature .	68	(•	
	H 17 Bev 7/20	00	and the same of	Jan					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend, item 23a, per doc 2900, 2-18-10 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 01=15 PM chruory 2010 <u> Harold Elias Yoder</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown Seasons Hospice | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Feb. 18, 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**A** M 2□ F 96 Indiana Director 307-01-8354 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10h. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland | Baltimore Gwynn 0ak 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21207 United States Funeral 6811 Campfield Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2**X** No þ Specify: White 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baking Supply Miller .. Pages 1 and 2 should be filed w iment of Health and Mental Hygie tant: If item 27 is marked other t jury or other traumatic event, II. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith Garman Albert Yoder 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1108 Somerset Place, Lutherville, Maryland 21093 Dr. Milton G. Yoder/ Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 15. 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State permit. Page Department or Important: If any Injury or Metro Crematory, Inc. 2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facili Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.

Do not enter the mode of dying, such as cardiac or respiratory arrest, End Stage Renal Disease Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo for as a consequence of burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician law requires that the death certificate be Physician/Medical use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown us certificate has been signed director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? or Attending Physician: The 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 NO Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Thr + Ho) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred i 🔁 🗖 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ภ 24 hours ar ne Funeral เ Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Autoxion Blug 2106 MO bach 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Mable Artis February 2010 2:30 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🖾 F Months Days Hours Min (Month, Day, Year) ()7/19/192 Country) Director 243-22-5938 88 Carolina Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Baltimore 10e. Street and Numbe 10f Zip Code 10g. Citizen of What Country? Funeral 423 Edgewood Street 21229 U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 K Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bookbinder Book Production Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Reeves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian McCarly / Daughter 423 Edgewood Street, Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 02/17/2010 Anatomy Gifts Registry Hanover, Maryland 21. Signature of Funeral Service 🖟 22. Name and Address of Facility Anatomy Gifts Registry >0 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ an una disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 \(\sum \) Yes 2 \(\sum \) No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q Failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

1 Yes 2 No this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director; After this certifical completed filled in by the funeral director; 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 X No 1 Tes Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 📈 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R149194 Hebruan 16,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grant Charles 701 N. Towson, MD 21200

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

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			for State Registrar	Otate of Wil	ai yidiid		tificate of L			g. No. 2010	0 4 4 4 2			
	Physicia	ın/	1. Decedent's Name (First, Middle, Las	t)	000	-C 05		- '	2. Date of Death Month	Day Year	3. Time of Death			
,	Medic Examin	al	STEPHEN 4a. Facility Name (if not institution, give	street and number)	Mrc	5505		Location of Death	FEBRUAR	4c. County of Deat				
· John State				BAYVIEW			_ BA	LTIMORE						
	Funeral Director		5. Social Security Number 6. Security Number 180–44–1326	^x X M 2 □ F 7. Age 43	(In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,) March 2	9. Bin Co. 8.1966 Pe	thplace (State or Foreign untry) ennsylvania			
		_	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	eation			10d. Inside City Limits				
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	h the Maa or 24	al Dir	10e. Street and Number	Court		-	10f. Zip Code	og. Citizen of What Co United Sta	ountry?					
	ems 23	4 Chapel Manor Court 21128 United 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Armed Forces? Armed Forces? Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-life Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Right									rican Indian,			
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Ē,	Mrs. Antigoni Apesos (Wife) 4 Chapel Manor Court Perry Ha 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Method of Disposition 2 Date cemetery, crematory or other place) 20c. Method of Disposition 2 Date 20c.										c. Location - City or Town, State			
Baltimore, Maryland 21215-0036	Page tment tant: If jury or	7	1 🄀 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify)			Cemetery	$2/\frac{2}{1}$	2010	Baltimore	, Maryland			
Bal	permit. Page 1 a Department of F Important: If ite any injury or ot		21. Signature of Funeral Service Licens	Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, Maryland										
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between			
~	h sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a	94010		MONA	LY ARRE	ST		Onset and Death			
	Examiner			Due to (or as a	5CV	/ <u> </u>								
	p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequen	ce of):					4			
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	ite be e hysicial he buri	dical		d										
687	ath certificate be attending physici for use as the bu	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Date of de	liverv			
Box 68760	death o	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregnand Other (specify)	:у		Month	Day Year			
0	requires that the de been signed by the should be detached	/ Phy	g ☐ Unknown Part II. Other significant conditions co		ut not resultin	ng in the ur	nderlying cause giv	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?			
JS, F	uires then signer and be o	ed by							1 🗆 Yes	2 □ No 3 □ P	robably 4 Unknown			
cor	law req nas bee e 2 sho	Completed							24a. Was an autopsy perform	prior to	topsy findings available completion of cause of			
l Re	sician: The law is certificate has birector, page 2 s		25. Was case referred to medical				26 DI	ace of Death (Check	1 ☐ Yes 2		s 2 □ No			
Vita	nysicia lis cert directu	To Be	evaminer?	Hospital: 1	ent 2 ER	/Outpatien	Othy)F'		ce 6 Other (Spec	ify)			
Division of Vital Records, P.O.	Attending Physician: or death. ector: After this certific by the funeral director.	Certificate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injur (Month, Day		b. Time of injury	28c. Injury work M 1 🗆		28d. Describe how	injury occurred				
isio	Attender deat ector:	2 Accident Investigation 3 Suicide 6 Could not be determined lowering at the following street and Number building, etc. (Specify)												
Ö	pital or ours aft eral Dir filled in						naved at the time	data and place an			stad			
T	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Examinonly one) 3 Certifying Nurs	ner: On the basis of ex	amination an	d/or investi	gation, in my opinio	on, death occurred at	the time, date and	place, and due to the	cause(s) and manner stated.			
V	vith vith		29b. Signature and title of certifier				29c. License	number	29	d. Date signed (Mont)	n, Day, Year)			
			30. Name and address of person who co	ompleted cause of de	ath (Item 23	a) (Type, Pi	rint)	11/0/21		2 10-06	// //			
			William T.	HOSEKM	5 4	140 €	ASTERN W	VENNE B	ALTIME	2-10-20	21224			
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	del								

Please Type or Print in Black Indelible Ink, 25, 2010, WS Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death James Ashe Sr. 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** Februan 1142010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1 【 M 2 🗆 F 214-38-8997 07 27 Director 68 41 NC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location show 1 Yes 2 □ No Director items 23a or 28a-f s ner must be notified MD NΑ Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 3907 Mortimer Ave 21216 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 💥 No If Yes, Give Year or Dates: Specify. ج Specify: Black 3X Widowed 4 □ Divorced ?7 is marked other than "natural", traumatic event, the Medical Exa Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 9th grade Drapery Mechanic Bergman's Cleaners na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert Ashe Eleanor Simpson ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health ar Important; If Item 27 is any Injury or other trauonce. Eleanor Bland-Daughter 3019 Mondawmin Ave, Baltimore, Md 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arbutus Memorial Park 2/23/10 Arbutus, Md 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licenses 4300 Wabash Ave, Baltimore, Md 21215 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Part Enter the disease, or comshowk, or heart failure. List only Approximate Interval Between mmed te Cause (Final e or condition resulting in death) Carlord **Physician** /Medical Due to (or as a consequence of) **Examiner** TUNOY Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and Due to (or as a consequence of) Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? Day Pregnant at time of death 2 No d by the ald Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Hospital: Inpatient 28a. Date of Injury Other: 4 \sum Nursing Home 1 Tes 2 XV0 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) မ 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 2 Accident 5 Pending investigation (Month, Day Year) 1 Tes 2 No 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) within 24 hours a the Hospital Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. соmpletely (check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 February 14,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BYDON MOHAMAD 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) FEB 19 Registrar's Signature State 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For	State of M	arylan	d / Depa	artmen	t of H	ealth ar	nd M	lental Hy	gien	е			
			State Registrar			Cer	tificate	of D	eath			Reg. N	0.20	10	0444	Ļ
	Physicia Medic		Decedent's Name (First, Middle, Kenneth	Last) S₊			Alten	burg			2. Date of De Month Februa	D	ay	Year	3. Time of Death	
	Examir		4a. Facility Name (if not institution, Union Memorial I	-					ocation of l	Death					,	
	Funeral Director			-		ast birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Hrs. Min.	8. Date of Bir (Month, Da June 1	th ly, Year)	40	9. Birthpl Countr Mary	ace (State or Foreigr)
			Usual Residence of Decedent		60						June 1	, 194	49 [.			_
	aryland la-f sh ified a	ecto		Arundel	10c. City	r, Town or Loc Pasa								10	ld. Inside City Limits 1 ☐ Yes 2 ☐XNo	
	h the M 3a or 28 be not	al Dir	10e. Street and Number			2.000	10f. Zip	Code 211	22			10g. C	Citizen of W	hat Count		
	eath wit tems 2: er must	Funeral Director	8434 Miramar Roa	12. Was Decedent 8	Ever in U.S		Vas Decede	ent of His	panic Origin	n? (Spec	cify Yes or No-		USA 14. Race	- America	n Indian,	_
036	s after d ral", or i Examin	by	1 🏻 Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2X If Yes, Give Year or Dates.	No		Yes, speci		, Mexican, F Specify:	Puerto F	lican, etc.)		Black	white, et Whit	tc.	
21215-0036	72 hour n "natu ledical	Be Completed	15. Decedent (Specify only highes			16a. Deced	aind of work	done du	tion tring most of	f workin	g	16b.	Kind of Bus	siness Indu	ustry	
212	within /giene. ner tha t, the N	e Con	12 years	College (1-4 or 5	5+)		orer	retirea)	_			Rı	ubber	Comp	any	
Maryland	be filed ental Hy ked ott ic even	To B	17. Father's Name (First, Middle, La Roland William A	,							(First, Middle, E. Ba		Surname)			
ary	hould and M s mar umat		19a. Informant's Name/Relationship			19b. Mailin	g Address	(Street an			Route Numbe		r Town, Sta	ate, Zip Co	ode)	_
	ealth a m 27 i		Edith C. Altenbu	urg Step-mo	other						adena,				122	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp		CE	lace of Dispos emetery, crem View C	natory or oth	her place,		ebrü 8, 2			ocation - 0	-	_{m, State} Iaryland	
Balt	permit. Departr Imports any inji		21. Signature of Funeral Service Lic	rensee		7 7	Name and Onne I 110 S	Ty F		<u> </u>	me of Road,	Duna Duna	dalk,	P.A. MD. 2	21 222	
			23a. Part 1. Enter the disease, or c shock, or heart failure. List on	omplications that caused ly one cause on each line	the death	. Do not ente	r the mode	of dying,	such as car	rdiac or	respiratory an	rest,	· · · · · · ·		Approximate Interval Between	1
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760	cate be physic s the bi	edical		d												_
Box 68760	attending p	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live Birth			Ectopic pr	regnancy					23d. Date	of deliver	y	
. Bo	that the deati ned by the att detached fo	Physician/M	1 Yes 2 No 9 Unknown	4 ☐ Pregnant a 9 ☐ Unknown			Other (spe						Mon	th C	Day Year	
s, P.O.	es that t signed b		Part II. Other significant condition	s contributing to death b	ut not resu	ılting in the ur	nderlying ca	ause give	n in Part I.			obacco Yes 2	/		cause of death?	
ords	aw requires that see the seen signer 2 should be	Completed by	ſ					-			24a. Was	an	24b. W	ere autops	y findings available	_
Rec	sician: The la certificate ha irector, page 2										autop perfo 1 🗆 Yes	rmed?	de	eath?	pletion of cause of	
ita	sician certifi rector	m	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:				Other	e of Death (_
Division of Vital Records,	ding Phys h. After this (funeral dir	ite: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	1 ☐ Inpatie 28a. Date of injur (Month, Day	y [R/Outpatient 28b. Time of injury		c. Injury a	4 L Nursi		ne 5 🗆 Resid Bd. Describe h					_
sion	Il or Attendii after death. Director: Ai d in by the fu	Certificate:	2 Accident Investiga 3 Suicide 6 Could no	tion of be			M et, factory,	1 □ Ye	es 2 🗆 No		8f. Location (S	treet an	nd Number	or Rural R	oute Number	-
Div	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	<u>8</u>		building, etc	. (Specify)						City or Tow	n, State)			į
)	To the Hospital within 24 hours a To the Funeral C completed filled	Medical	(Check 2 L Medical Exa	hysician: To the best of a miner: On the basis of ex lurse Practioner: To the l	camination	and/or investig	gation, in m	y opinion,	death occur	rred at tl	ne time, date a	nd place	e, and due t	to the cause	e(s) and manner state	d.
4	Vith Con Con		29b. Signature and fittle of certifier	2			29c. I	License n) A.		-	ite signed (ıy, Year)	
		-	30. Name and address of person when	no completed cause of de	eath (Item 2	23a) (Type, Pr	int)	100	<u> 5353</u>			1-e	brua	CY 1	5Th 2010	_
			Robert Linton.	II, M) Ur	Unn /	Memor	IN Ho	ospita	1 Bo	eltir	nore,	MI)			
	Stat Registra	-	FEB 1 9 20	32. Registra	s signatu	park		,								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per me, g900,02/18/2010dhb trar Certificate of Death Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** NILLIAM BAHN 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Columbia Howard Howard County General Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1⊠M 2□ F Director 69 Sep. 16, 1940 230-46-0003 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f shov 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, 1 m M dical Explaint in the court by 1 ☐ Yes 2 No Director Maryland Howard Ellicott City 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 8125 Q Hickory High Court 21043 United States filed within 72 hours after death Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 63-66 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify: \$ 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Manager Retail Management 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be f th and Mental Edward Frank Bahn Maxine Bowers Coffman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21043 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai once. Jane Bahn/ Wife 8125 Q Hickory High Court Ellicott City, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State January 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Baltimore, Maryland Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Cremation Society of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 Alice Iser 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPTIC Immediate Cause (Final >40C)< **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner NEUMONIA Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner Due to for as a consequence of ASPIRATION physician a s the buriaf-t O. Box 68760 Physician/Medical attending pl IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) the a ☐Yes 2☐No 9 Hinknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ GASTRO INTEST IN AL BLEEDING 1 Yes 2 No 3 Probably 4 Unknown Completed CHRONIC OBSTRUCTIVE PULMONARY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 LAPAROTO MY performed' EXPLORATORY 1 ☐ Yes 2 WNo 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 (D) Certification: To this funeral 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After the Hospital or Attending (Month, Day, Year) 5 Pending investigation death. 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director: the 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Filled 1 Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mo DO043662 Jan 28, 2010 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William J. Boyce Howard 31. Date filed (Month, Day, Year) FEB 192 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Gina M. Bleggi рM February 2010 4:44 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Rockville Montgomery Shady Grove Medical Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. (Month, Day, Year) 231-31-2894 Director 26 1983 D.C Nov Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifited at any injury or other traumatic event, the Medical Examiner must be notifited at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Gaithersburg MD Montgomery 1 🗆 Yes 2 😿 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9109 Bannister Lane 20879 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Never Worked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bleggi Scott Bleggi Nancy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9109 Bannister Lane, Gaithersburg, MD 20879 Scott E. Bleggi / Father Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔲 Burial 2 😾 Cremation 3 🗆 Removal from State 2/10/2010 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crem. Woodbine, MD Signature of Funeral Service License Dorota Marshall Name and Address of Eacility
Maryland Cremation Services Mariha PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physiciani Holoprosence haly disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Vegetative State Sequentially list conditions Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER if any leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events consequence of as the burial-transi attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 | Fetal dear in the past 12 months?
1 Yes 2 No Day Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 1 Yes 2 No 2 X No Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 X Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death.

Director: After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D 59013 2.4.2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Kuludena,

31. Date filed (Month, Day, Year

Registrar's Signatu

M.D. 15825 Shady Grove Rd., Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Brown 1420 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Bultimore John Hopking Beltim u/en Funeral 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1XXM 2 □ Days Hours Min Months Country) Illinois Director 330-01-7399 89 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits Baltimore Dunda1k 1 ☐ Yes 2 No 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 7536 Ives Lane 21222 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1X Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 3 Widowed 4 Divorced Specify: Year or Dates. WWII 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Movie Theaters Elementary/Seconday (0-12) College (1-4 or 5+) Entertainment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Grace Eastman Faye Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7536 Ives Lane Dundalk, Maryland Mrs. Joyce E. Brown (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🕅 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns. 2/19/2010 Middle River, MD Signature of Janeral Serve Lice ^{22. Name and Address of Facility}
Duda-Ruck Funeral Home of Dundalk,
7922 Wise Ave. Dundalk, Maryland wha Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Approximate shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) umonis Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Dav Year the g Unknown s been signed by a should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy director, page perform certificate l rmed? 2-1 No 1 Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 's after death. al Director: After this ce Hospital 1 🗌 Yes 2. No Other: ည Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending work? Accident 2 🗌 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined a 24 hou. che Funeral Dire City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2

To the I

comple only one) 29b. Signature and title of certifier 29c. License numbe

iotl

DHMH 17 Rev 7/2009

State

Registrar

Ctr.

Todd Jenn

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johns Hopkins Bayview Medical

31. Date filed (Month, Day, Year)

9097

4940 Eastern Ave.

Todd Senn, M.D.

Baltimore,

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3^{Day}2010 **Physician** Month FEB LEO J. BROGAN 13 8:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, August 8, 9. Birthplace (State or Foreign Country)
Massachusetts **Funeral** 19<u>16</u> Months Days Hours 1 X M 2 □ F 93 Director 032-03-3106 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show ral", or items 23a or 28a-f shov Examiner nast be notified at 1 ☐ Yes 2 X No Director Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 4103 Weller Road 20906 United States Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23.
ury or other traumatic event, I'm. Motical Examination man 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give WWII Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1∐Yes 2∭XNo Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4or 5+) Government Lawyer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Nicholas Brogan Eleanor McCue ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Ann Brogan / Daughter 5218 Marvell Lane, Fairfax, Virginia 22032 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) February Gate of Heaven Cemetery 19, 2010 Silver Spring, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814—3501 21. Signature of Funeral Service Licensee selette Daynie M01305 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Ent. I have cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the death certificate be executed ending physician and use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached □Yes 2□No 9 Unknown 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural To the Hospital or Attendir within 24 hours after death.
To the Funeral Director; At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier l 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

31. Date filed (Month, Day, Year)

title of certifier

LT

MC

29b. Signature and

30. Name and address of

LYNN BYARS

USN Registrar's Signature

use of death (Item 23a) (Type, Print)

29c. License number

0101240414 (VA)

NATIONAL NAVAL MEDICAL

BETHESDA MD 20889-5600

29d. Date signed (Month, Day, Year)

CENTER

10-01393

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 04449 State of Maryland / Department of Health and Mental Hygiene John M. Busch 1. For State Certificate of Death Reg. No. Registrar 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Year 0720 hrs ical Examiner John Merle Busch February 16, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore County** Rosedale Franklin Square Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Davs Hours Country) Maryland Director 46 06-03-1963 1 X M 2 F Yrs 212-62-6078 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 X No or items 23a or 28a-f show must be notified at once, Perry Hall Maryland Baltimore be filed within 72 hours after death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6 Steven Way 21236 **USA** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. "natural", or items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married Yes White 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify 3 Widowed ð 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) s. I and 2 should be filed within 72 ho of Health and Mental Hygiene. If item 27 is marked other than "n her traumatic event, the Medical E. Flementary/Secondary (0-12) College (1-4 or 5+) Master Electrician 12 Contractor 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Andrew Nancy Lee Stangle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Perry Hall, Mrs. Susan Busch - Wife 6 Steven Way Maryland 21236 If item 27 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition timore, crematory or other place) permit. Pages l Department of H Important: If it 1 Burial 2 X Cremation 3 Removal from State injury or other 02/18/2010 Towson, Maryland Hilltop Service Corp. 4 Donation 5 Other Specify 22. Name and Address of Facility 5305 Harford Road 21. Signature of Funeral Service Licensee Leonard J. Ruck, Inc. Baltimore. MD 21214 per DVR Charles F. Miner, JR Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Hypertensive atherosclerotic cadiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit AMENDED #21 Per FH G900 2/22/2010 JH cian/Medical X UNPENDED attending physician for use as the burial 23a,27,permE, g901 3.3.10 TT Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the a I be detached fo 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 V Unknown Completed ficate has been si 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy this certificate has performed' ✓ Yes 2 No 1 V Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this comiff 25. Was case referred to medical Other: Nursing Home 5 Residence 6 Other: Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA 2 No 1 V Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b Time of Injury 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No 5 Pending the Accident completely filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 🗸 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number February 17, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ling Li, MD

OCME

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32. Registrar's Signature

a read

31. Date filed (Month, Day, Year)

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2010 Rhraam John J. Bernarding III /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** KOS TIMORE Savare eda 7. Age (In yrs. last birthday) 72 Yrs If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral 1** M 2 □ F Months Days Hours Min Director 217-34-4037 October 13,1937 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Director Balto. Middle River 1 ☐ Yes 2 🛣 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7203 Oliver Beach Rd. Funeral 21220 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian ¶Yes 2 If Yes, Give 1 Never Married 2 X Married If Yes, Give 1958–1964 Year or Dates: 1 ☐ Yes 2 ▼No Specify δ. White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Type Setter Printing 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (John J. Bernarding Mathilda Jansen ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antoinette Bernarding Spouse 7203 Oliver Beach Rd. Middle River, Md. 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood 2-20-2010 Parkville, Md. 21. Signature of Juneral Servi e License 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (ar as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: esn If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown eumonio 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

1 Yes 2 No certificate 2 No 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient
Date of Injury 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Aftert 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. License number 29b. Signature of certifier 29d. Date signed (Month, Dav. Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Square Dr. Balhmore, MD 21237 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2010° 9:55 AM Margaret Elizabeth Kay Black Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Candlelight Cove Talbot Easton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Month, Day, Year)

[11] Month, Day, Year) 1 🗆 M 2 🗶 F Months Days Hours Min. Director 216-45-4055 Maryland 88 June Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 😿 No Maryland Talbot Easton ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 8363 Aveley Manor Lane 21601 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, ò Black, White, etc. 1 Never Married 2 Married þ 1 Yes : 2 **X** No within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" Completed 3 X Widowed 4 ☐ Divorced Year or Dates White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) n/a Secretary Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Kay Andrew Jessica Martha Pangborn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean R. Weisman/Daughter 8363 Aveley Manor Lane, Easton, MD 21601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Date 20c. Location - City or Town, State Donation 5 Other (Specify) 2/26/10 Meadowridge Mem. Park. Elkridge, Maryland Signed of United Service licen. 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 23a. Part . Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only Immediate Cause (Final Interval Between Onset and Death Ph_sician/ disease or condition resulting in death) ongesture Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or impury Due to (or as a consequence of): as the burial-transit Exam that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for 5 Other (specify) Month Day Year g Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Division of Vital Records, Completed 1 ☐ Yes 2, ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed^{*} this certificate 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🛮 No Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Iniury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier

State Registrar

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(Check

3 🗆 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PASCHER MD

2 Martin

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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29d. Date signed (Month, Day, Year)

29c. License number

(Our

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** BUTLER TUNIUS Februar 2070 /Medical 10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Under 24 H 5. Social Security Number 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day May 8 Funeral 1 M 2□ F 230-60-093 Months Days Hours Director irainia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 Yes 2 No Funeral Director Itimore 10e. Street and Numbe 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examinat must be re 62 nor 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or iten Black, White, etc. 1 ☐ Never Married 2 💢 Married altimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) boro Nalbrook 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ ohnson 19a. Informant's Name/Relationship (Type. Print) [COUSIN] 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) homa 20a. Method of Disposition Dațe Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Sign were of Funeral Service Lice 22. Name and Address of Colliny OSEPH L. RUSS Fur 2222 W. North Ave. Home, P.A. e. Balto. Md. 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNUEMONIA **Physician** /Medical Due to (or as a consequence of): Examiner 22104 METASTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner certificate be executed HEPATO sician and burial-trans Due to (or as a consequence of) attending physician Physician/Medical RTERIOSCLEROTIC the as IF FEMALE for use a 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.0. cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 LUNG D155 € 1 Yes 2 No 3 Probably 4 Unknown 013 STRUCTIVE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy certificate Division of Vital 2 **2** No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MID. D 23300 February 10 2010 BON SELONES

Registrar DHMH 17 Rev 1/2001

State

17

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

SUDMIR 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1118 **Physician** FEbruar Brown aure 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital hultst Randallstown Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 K F Oct 29, 330-05-9988 Director 1918 Minnesota Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is Martical Examiner mans in contrast. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County MD **Funeral Director** Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2540 McCullom Street 21217 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ★ Married Baltimore, Maryland 21215-0036 black 1 □Yes 2 No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Capital Elementary/Secondary (0-12) 12 College (1-4or 5+) librarian Planning Committee 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aimee Hall Matthews David Henry Hall ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Glenn M. Brown/son 2005 Royal Garden Dr.; Woodlawn, Maryland 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ward State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line.

Immediate Subse (Final disease or condition resulting in death)

a. Due to (or man consequence List) Approximate Interval Between Onset and Death **Physician** hours /Medical a conse uence (f): Due to (or Examiner TIGH if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Manl that initiated events resulting in death) Last for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Be Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No nwan rac 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1□Yes 2▼No Other: 4 \sum Nursing Home 1/2 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) filled in by the funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Hospital 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d Date signed (Month, Day, Year) 29b. Signature and title of coftifier 40068505 5,2010 who completed cause of death (Item 23a) (Type, Print)

State Registrar 540

31. Date filed (Month, Day, Year) FEB 19 201

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** WILLIG /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Funeral 1 X M 2 F 219-30-5238 75 Oct 28, 1934 Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at MD Baltimore Baltimore 1 X Yes 2 No Director 10e, Street and Number 10f. Zip-Code 10g, Citizen of What Country? 21224 USA 2331 Fleet Street Funeral 12. Was Decedent Ever in U.S. Armed Forces?Unk 1₺ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status ral", or iten Examiner r Black White etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2X Married 3altimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No þ Specify: 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Bethlehem Steel iron worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be is marked ot Zella Mae Crockett Clifford Vivian Bowen ည traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2331 Fleet Street; Baltimore, Maryland 21224 19a. Informant's Name/Relationship (Type. Print) Arlene Bowen/wife Health tem 27 other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or o once. cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 5 Other (Specify) 4 🕅 Donation Funeral Ser Ronald 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a, Part 1 Approximate Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or injury that initiated events the attending physician and ched for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death
Unknown 5 Other (specify) 2 No page 2 should be detached P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I à of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 2 No 1 TYes 1 Yes 21 certificate Physician: 25. Was case referred to medical completely filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 JUNO 1 npatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: s after death. Division or Attending 5 Pending investigation Injury 1 🗌 Yes 2 🗆 No 2 Accident 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year) FEB 192

JONATHAN



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

KES-000

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Feb. 2010 Howard F. Brenner 4:15 РМ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3509 Dairy Valley Trail Ellicott City Howard 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Dec. 3, 1929 Birthplace (State or Foreign Country) 1 X M 2 | F Days Hours Min. **Director** 170-24-3485 PA Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3509 Dairy Valley Trail 21042 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 🔀 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced ortant: If item 27 is marked other than "natur injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Accountant Life Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Howard Brenner Louisa Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard F. Brenner, II / Son 1709 Deer Park Rd., Finksburg, MD 21048 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/20/2010 rest Lawn Mem. Gdns. Marriottsville, MD 21. Signatura of Fureral Service Licensee M01411 22. Name and Address of Facility Harry H. Witzke's Family Fil, Inc. 4112 Old Columbia Pike, Ellicott City, MD 21043 ant 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Ph sician/ Onset and Death disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last signed by the attending physician and defeached for use as the burial-transi Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' After this certificate Yes 2 N 25. Was case referred to medical Hospital or Attending Physician: Be 26. Place of Death (Check only one) 1 Tyes 2 No မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one

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Division or Vital Records, P.O. Box 68760.

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Physici /Medic				Helen	Boswe	ell				Month	Feb 17, 20	Year 10	8:05 A ^M
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			Marylar	nd Masonic Hom	1e			Cod	keysvill	е		Balt	imore
Funeral		5. Social Security	Number	6. Sex 7. Ag	ge (In yrs. las		If Under 1 Ye Months Da		nder 24 Hrs.	8. Date of B	irth	9. Birthp	lace (State or Foreign
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land ow		10a. State	10b. County		10c. City,	Town or Lo	ocation					1	0d. Inside City Limits
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ems :	Funeral Director	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decedent of If Yes, specify C	of Hispanic	Origin? (Spe	ecify Yes or N	o- 14. Ra	ce - Americ	
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and 2 and 2 ealth a n 27 is		Charles	Boswell s	on			8 Hollowo						·
D		20a. Method of Dis	sposition	3 □Removal from State	20b. Plac	ce of Dispo	sition (Name of matory or other)	olace)		Date	20c. Location	- City or To	wn, State
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permit. Departr Imports any inji	13	21. Signature of F	uneral Service	icensee	A	22	2. Name and Ad		,				
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		23a. Part1. Enter shock, or he	the disease, or cart failure. List o	omplications that cause nly one cause on each li	the death.	Do not ent	er the mode of	dying, such	as cardiac o	or respiratory	arrest,		Approximate Interval Between
Physician		Immediate Cause	(Final	Gred	Har	e D	enerita						Onset and Death
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The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was deceder	nt prognant	23c. If yes, outcome	pf pregnanc	:y					234 D	ate of delive	in.
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s that	by P	Part II. Other sign	ificant condition	s contributing to pleath b	ut not resulting	ng in the u	nderlying cause	given in Pa	art I.	23e. Did	tobacco use con	tribute to th	e cause of death?
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Attending Physician: r death. ector: Affer this certifica by the funeral director, I	2	examiner? 1 ☐ Yes 2	No	Hospital: 1 ☐ Inpatie	ent 2 ER	R/Outpatien	ıt 3□ DOA	Nata a m			idence 6 □Ot	her (Specif	()
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or At frer d Direct n by	Ě	3 ☐ Suicide 4 ☐ Homicide	determin		ury - At home c. <i>(Specify)</i>	e, farm, str	eet, factory, offic	e	1	28f. Location (City or To	(Street and Num. wn, State)	ber or Rura	l Route Number,
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only	1 CertifyIng 2 Medical E	Physician: To the best xaminer: On the basis or	f examinatior	edge, death n and/or in	n occurred at the vestigation, in m	time, date y opinion,	e and place, a death occurr	and due to the ed at the time	cause(s) and m	anner as st	ated. the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	
State of Maryland / Department of Health and Mental Hygiene 20 10	0
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			For State Registrar	Plea				d / Depa		Health ar	e All Copie nd Mental H		e2010	041	+57		
	Physici /Medio		1. Decedent's Name	Virg	inia			alier				ary	ay 17, 2010				
	Examin	er	4a. Facility Name (li 7511 G1		-				4b. City, Town, o	or Location of [.esda	Death	4	c. County of Dea Montgo				
200	Funeral		5. Social Security N		6. Sex	7. Ag	e (In yrs. I	ast birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of	Birth		thplace (State o	or Foreign		
L	Director		213-48-32 Usual Residence of		1 🗆	M 2 🕅 F	95	Yrs.	Months Days	Hours	Min. 8. Date of 1 (Month, July)	13, Year	914 Vir	ginia			
	ryland how	_	10a. State	10b. County			10c. City	, Town or Lo	cation					10d. Inside Ci			
	se Ma 8a-f s	cto	Maryland	Montg	omer	У		Beth				,		1 ☐ Yes	2 X No		
	a or 2	Ö	10e. Street and Nun		1. n.				10f. Zip Code	20017			itizen of What Co				
	ns 23	Funeral Director	7511 G1	enbroo.		2. Was Decedent	Ever in U.S	5 13.3		20814	n? (Specify Yes or		United S				
36	be filed within 72 hours after death with the Maryland stal Hygiene. 4d other than "natural", or items 23a or 28a-f show event, the Medicel Exa-diverment be notified at	by Fun	1 Never Marri			Armed Forces? 1 ☐ Yes 2 💢 I If Yes, Give	1 □Yes 2 X No						Black, White, etc. Specify: White				
9-0	2 hou atura	ted		15. Decedent	's Educ	ation		16a. Dece	Decedent's Usual Occupation			16b.	 Kind of Business	Business/Industry			
21215-0036	2 should be filed within 7 and Mental Hygiene. is marked other than "n aumatic event, the Med	Completed	Elementary/Secon	ify only highes ndary (0-12)	st grade	College (1-4or 5	i+)		kind of work done DO NOT use retire stered Nu		working Homemaker	Nu	rsing /	Own Hom	ne		
	al Hyg l othe	Be C	17. Father's Name (First, Middle,	Last)					18. Mother's	Name (First, Midd	lle, Maide	n Surname)				
Maryland	Ment Ment arked	인	George	Murra		ates				Sall							
Mar	ges 1 and 2 should t of Health and Men If item 27 is marke or other traumatic		19a. Informant's Na Richard 1										City or Town, State, Zip Code)				
	1 and 2 s Health a tem 27 is	20	20a. Method of Disp		ше	r / 3011	20h P				Date		, Maryia				
μ	ages ent of tt: If it y or o		1 🛭 Burial 2	Cremation		moval from State			sition (Name of matory or other pla		bruary	1	hington				
Baltimore,	permit. Pages I Department of I Important: If ite any Injury or of	Rock Creek Cemetery 22, 2010 Washing 2 Grandston 5 Gother (Specify) 21. Signature of Funeral Service Licensee MO1305 Rock Creek Cemetery 22, 2010 Washing 22, Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethes 77557 Wisconsin Avenue Rathesda Maryla															
8	<u>89 E E 8</u>		CINGA	21. Signature of Funeral Service Livensee M01305 Robert A. Pumphrey Funeral Home / Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Step the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Interval Between													
			23a. Fart 1. Foller shock, of hear Immediate Cause (rt failure. List	complic only one	ations that caused cause on each li	the death ne.	n. Do not ent	ter the mode of dy	ing, such as ca	rdiac or respiratory	arrest,		Approximate Interval Bet Onset and I Years	e ween Death		
	Physician /Medical		disease or condition resulting in death)	n	_ a.	Strol Due to (or as		ience of).						reals			
7	Examiner						rtens							Years			
	i d	ner	Sequentially list con if any, leading to im- cause. Enter Univer Cause (Disease or that initiated events	nditions, mediate) b.	Due to (or as	a consequ	ience of):									
	ecute and trans	Examiner	Cause (Disease or i that initiated events resulting in death) L	ińjury .ast	c.	Athe Due to (or as			c Cardio	vascula	r Diseas	j		Years			
760,	icate be executed physician and s the burial-transit	g	,		d.	Due to (or as	a consequ	ience on).									
Вох 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent in the past 12		23	1 Live birth	come of pregnancy irth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy						23d. Date of de		Year		
0	that the de ned by the a detached f	ysic	1 □ Yes 2 🛭 9 □ Unknown			4 ☐ Pregnant a 9 ☐ Unknown	t time of d	eath 5	Other (specify)			.					
ď.	s that ned b e deta	by Pt	Part II. Other signifi	icant condition	ns cont	ributing to death b	ut not resu	Iting in the u	nderlying cause gi	ven in Part I.	23e. Di	d tobacco	use contribute t	the cause of d	leath?		
ğ	w requires been sign should be	ed b									1[]Yes	2 X No 3 □ P	robably 4□l	Jnknown		
of Vital Records,	law re as be 2 sho	Completed				·					24a. W	topsv	prior to	utopsy findings of completion	available		
<u> </u>		E O									pe 1 □ Yes	rformed?	death? lo 1 ☐ Ye:	s 2 □ No			
/ita	sician: Th certificate irector, pag	Be	25. Was case referr examiner?		11/2	ospital:			Lou		Death (Check onl	y one)					
of	this al dir	은	1 ☐ Yes 2 🛣 27. Manner of Death		no	1 ☐ Inpation		ER/Outpatier 28b. Time of	" 3 L DOA		ng Home 5 X Re		6 ☐Other (Spe	ecify)			
0	Ing Afte	tion	1 Natural 2 Accident	5 Pending		(Month, Da	y, Year)	Injury	Wo	rk?]Yes 2∐No		e now inj	ury occurred				
Division	I or Attendi after death. Director: A I in by the fu	Certification:	2 Accident A									and Number or R te)	ural Route Num	iber,			
_	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Medical C	29a. Certifier (Check only one)	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)													
	To the within To the comp	Me	29b. Signature and	title of certifier				, L	29c. Licen	se number		29d. D	ate signed (Mon	th, Day, Year)			
			Na	ma	1	Dave	mp	017	D41	507		Feb	ruary 19	, 2010			
7	-		30. Name and addre							ıe, NW,	Suite 20)2, W	Vashingt	20016 on, D.C			

State Registrar 31. Date filed (Month, Day, Year) FEB 19 2010

DHMH 17 Rev 1/2001

37. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 0445 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 376 14 If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day) ge un vrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Director Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral th or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 💆 No Specify: "natural", 3 ₩ Widowed 4 □ Divorced Specify: Completed Year or Dates other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working id Mental Hygiene. marked other than ' ife. DO NOT use retired) Elementary/Seconday (0-12) Be Baltimore, Maryland 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should Department of Heath and M Important: If item 27 is man any injury or other traumati once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ととうと 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 201 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

JOSEPH L. RUSS

2.2.2. W. NOTT uneral Home 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) don Medical Due to (or as a consequence of): Examiner W Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner to for selectione actions are Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. Ş Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **To the Funeral Director:** After this certificate has been signed Is completed filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by PISE PSE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has r autopsy performed? certificate ! 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: မ 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 Natural injury 5 Pending s after death 2 Accident
3 Suicide 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral L Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) HOODA MI) INGH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospitaloj D. HOODA istrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 State of Mark and 37 39 20 For of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month William John Connolly \mathbf{P}^{M} Medical .30 EBRUARY 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Berlin Nursing Center Berlin Worcester 7. Age (In yrs. last birthday) Social Security Number 200–24–8938 If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Months Days Hours Min. July 7, 1929 Pennsylvania Director Yrs 80 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits MD Worcester Ocean City 1 Tyes 2 No 10e. Street and Number ò 10f. Zip Code er than "natural", or items 23a o 10g. Citizen of What Country? Funeral 14008 Sea Captain Road 21842 USA be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 🖾 Yes 2 🗆 No 1951 – If Yes, Give þ 1 Never Married 2 Married Black White etc WILLIAM // vland 21215-0036 1 Yes 2 No Specify: white Completed 3 Widowed 4 Divorced 1953 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. United States Postal Elementary/Seconday (0-12) College (1-4 or 5+) 12 letter carrier Be other traumatic event. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ဂ္ John Connolly permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once. Theresa Schuck 19a. Informant's Name/Relationship (Type, Print) CONNOLLY altimore, Mai 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Connolly/daughter 24 West Ave; Mt. Carmel, Pennsylvania 17851 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 🗔 Cremation 3 🗔 Removal from State cemetery, crematory or other place, 4 Donation 5 Tother (Specify) re of Funeral Se ics Licewa de State and Address of Jackson Street 855 W. Baltimore Street timore, Maryland 21201 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or a / consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury Due to (or as a consequence of): and -transit To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months? Day Yes by the a 9 Unknown Unknown s been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown has been 24a. Was an 24b. Were autopsy findings available page 2 autopsy performed? prior to completion of cause of death? After this certificate funeral director, pag 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medica 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Ecrtifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) K1351 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pennie Savage, CRNP Berlin Nursing Center Berlin, MD 32. Registrar's agnature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ Month AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death xudbern Maryland Hospital Cente ringa If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Month Days Country) Director INFANT Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Oxon Hill 1 Yes 2 X No Prince Georges ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be items 23a Funeral 20745 512 Wilson Bridge Dr. #B2 USA within 72 hours after death 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 Yes 2 No Specify "natural" 01) Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+ INFANT Elementary/Seconday (0-12) INFANT INFANT INFANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MINA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #B2 Aquala Diamond Covington/mother 512 Wilson Bridge Dr. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ♥ Other (Specify in state Sig at e of Funera Service Licens 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Director Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or iinjury Due to (or as a consequence of) Exam Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year the detached 9 Unknown g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: မှ 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide s after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title of certifie 29c. License numbe

State

Tark

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's signatur

Day 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month' **Physician** Daniel Paul Dickerson 20/4 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HILLOYE I Under 24 Hrs. Bat Limore State or Foreign 5. Social Security Number 8. Date of Birth **Funeral** Year) Months Days Min. 1 M 2 F Phiľaďelphia,Pa 140-74-3527 Director 8/16/1968 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits nt of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinator must be notified at Yes 2□No Director Salisbury 10f. Zip Code MdWycomico 10g. Citizen of What Country? 10e. Street and Number Funeral 20188 108 Walnut ST. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/ newsry Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) construction General Labor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Cyril Dickerson Helen Burns 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>James Lois Dilckerson</u> 29328 Will Street East Md 21601

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State Baltimore, 20a. Method of Disposition 1 ☐ Burial 2.☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important; If any injury or once. Ardent Cremations 2/26/2010 Hanover MD 21076 21. Signature @Funeral Service Lice Ardent Cremations 7522 Connelley Dr. Hanover MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** nsporter disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** SSDS/S Due to (dr as a consequence of) Sequentially list conditions 1. 21, 221, g to finine dict cause. Enter Underlying Cause (Disease or injury that initiated events Examiner he law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) signed by the attending physician be detached for use as the burial Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ,24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 No 2 **N**O 1 □Yes or Attending Physician: this certifica the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation after death. 1 □Yes 2 □No 2 🖺 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completely filled in by 4 🗌 Homicide To the Hospital or within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) SINGH HOODA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Since Mospital of Beltimore AJAY SINGH HOODA Year) Registrar

DHMH 17 Rev 1/2001

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Charles Edward Dotson 4, February 2010 1334 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital Baltimore City 8. Date of Birth (Month, Day, Sept 1, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Country) Maryland 66 Director 212-38-2179 Usual Residence of Decedent 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Madical Expedimental be notified at Director MD Baltimore City 1 XYes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3019 East Monument Street 21205 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian or i 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Black \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other fraumatic event, the Marian once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker Private 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold Sylvester Dotson Catherine Spincer ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne W. Dotson 3019 East Monument Street, Baltimore MD 21205 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Trinity Cemetery 2/15/2010 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Phillip A. Weatherford FS, P.A. 2431 East Oliver Street, Baltimore MD 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Intracranial Hemorrage **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760. physician Physician/Medical the as IF FEMALE: use yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) P.O. □Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Be Completed 1 Tyes 2XXXNo 3 TProbably 4 TUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 X No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one)

State Registrar 29b. Signature and title of certifier

12/25

Ryan Felling, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

DHMH 17 Rev 1/200

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

600 North Wolf St, Baltimore, MD 21287

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Feb. 13 Day 2010 2:30 PM Sr. M. Juliena Determan, R.S.M. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore The Villa 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Min. 1 □ M 2 🕌 Months Days Hours ΜĎ 212-24-0668 82 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County 1 □Yes 2X No Baltimore Baltimore 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21212 6806 Bellona Avenue IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health Care 12 5 +Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Marguerite Noon John Determan 19a. Informant's Name/Relationship (Type. Print) Religious 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mercy Drive, Belmont, NC 28012-2898 Sisters of Mercy-Ordér 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State Woodlawn Cemetery 2-18-10 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility} Bradley-Ashton Funeral Home 2134 Willow Spring Road, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or peach line. Immediate Cause (Final 10 YV Thorosderotic disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectonic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 \(\int\)No 1 □ Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

2

Completed

Be

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MD

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mudical Examiner must be notified at

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

and Mental Hygiene.

of Health a

permit. Pages 1
Department of F.
Important: If Itel
any injury or ott

altimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Puneral Director: After this certificate has been signed by the attending physician and burial-trar attending physician for use as the burial Physician/Medical ed by the a detached f certificate has been signed rector, page 2 should be det ≥ Completed director. Be Certification: To funeral filled in by the

(F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

5 ☐ Pending investigation 6 ☐ Could not be

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

ause of death (Item 23a) (Type, Print) 30. Name and address of person who completed Cutan

31. Date filed (Month, Day, Year,

32. Registrar's Signature

State FEB 19 2010 Registrar

Medical

To the within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ [□]1^y6, February Mary DiPaula Patricia 2010 2:22 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1249 Algonquin Road Crownsville Anne Arundel Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🗔 🗸 Sept 18, 1926 Mary Tand Months Hours Min. Director 212-22-6754 83 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 10d. Inside City Limits MD Baltimore Towson 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21204 1 Smeton Place #600 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. Š 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify: White 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Glen Burnie Coach Elementary/Seconday (0-12) College (1-4 or 5+) President Lines Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Callanan Michael Margaret Scallan Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James DiPaula, Jr.-son 1249 Algonquin Rd., Crownsville, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley 2/19/10 Timonium, MD 21. Signature of Funeral Service Licensee William G. 22. Name and Address of Facility Dau Ruck Towson Funeral Home, Inc. <u>1050 York Rd.</u> MD Towson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition carenows month Medical resulting in death) Due to (or as onsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy this certificate 1 Yes 2 No Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 🗌 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After to ompleted filled in by the funera Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3 2010 3 21093 30. Name and address of person who completed caus e of death (Item 23a) (Type, Print) York Road Luthewille CHRUSTINE LAFFERMON

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

192010

NID

32. Registrar's

1407

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#103 perFH, G900, 2/19/2010 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:42 AM James Anthony Dodson 'ebruary 06. 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 303 Limestone Valley Dr. Apt F Baltimore Cockeysville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Birthpiec Country) WVA 1 XM 2 - F Days Hours Min Months Director 233-76-3198 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Cockeysville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Century Apt. 363 Limestone Valley Dr. 21030 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James P. Dodson Florinda Frev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Dodson - brother 1008 Stane Road, Glen Burnie, Maryland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 02-18-2010 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fulleral Service De 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP., 7250 Wash. Blvd., Elkridge, MD 21075 Inc., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final anterios erotic (andiovasular Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any hading to immediate cause. Enter Underlying Examine Due to for as a consequence of and -transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Pregnant at time of death Day Year the signed by tall be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has ral director, page 2 autopsy performed? 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No ပ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After 1 Natural iniury 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier t 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 To the Within 2 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0038868 2-16-10 West Joppa Road Suite 306 huttowille MD 21093 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wintern. tz 2360 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 192010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ PO 10 REGIZUARY Ralph Haddaway Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death
EL GLEN BURNIE Examiner 4c. County of Death BALTIMORE WISCHINGTON MEDICAL CO BHME 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 **XX**M 2 □ F Months Hours Director 219-28-9464 82 Usual Residence of Decedent 3a or 28a-f shov t be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits 1 Yes 2XXNo MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ms 23a must b 7901 Camp Road 21122 United States ıral", or items 2 Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 2 □ No1945 Completed by Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: "natural", Specify: 3 Divorced 1948 White Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other tha College (1-4 or 5+) Machinist Chemical Metals Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Beverly Widerman Dixon Hallie Hazel Haddaway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7901 Camp Road, Pasadena, Maryland 21122 Margaret J. Dixon - wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State cemetery, crematory Meadowridge Mem Pk. 02-18-2010 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) al Service 21. Signature of Fun-22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP., Inc., 7250 Wash. Blvd., Elkridge, MD 21075 10. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CEREBROY ASCULAR Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 4 Pregnant a Pregnant at time of death 5 Other (specify) Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No After this certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ျ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury Investigation 6 Could not be Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier *Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: It has a built of the cause of the caus 29b. Signature and title of certifier 29c. License number 299. Date signed (Month, Day, Year) 045,49 3 and address of person who completed cause of death (Item 23a) (Type, Print 301 HEX

Registrar

State

FEB 19 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Vear Month **Physician** 9:30 a^M 8, 2010 JAMES THOMAS DORSEY February /Medical 4c. County of Death 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner FUTURE CARE SANDTOWN/WINCHESTER BALTIMORE 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** MARYLAND Director 101 MAR 15 1908 216-03-2161 Usual Residence of Decedent filed within 72 hours atter death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedleal Exercit natural termoffice and pines. 10a. State 1 X Yes 2 □ No Director MARYLAND BALTIMORE N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4605 ROKEBY RD., 21229 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 45/47 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify: BLACK þ 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BUSINESS OWNER 12th grade PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN HENRY DORSEY LOUISE WATKINS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4605 Rokeby Rd., Baltimore, Maryland 21229 Otha Davis/Great Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 02-19-2010 OWINGS MILLS, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 21. Signature of Funeral Service Users of 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. KRAUMINI 1206 W NORTH AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 10 where disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Physician/Medical the attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XÑo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🔀 Natural 1 ☐Yes 2 ☐ No 2 Accident nours after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 FC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. SANDHU 1940 W. BALTIMORE ST. BALTIMORE MD 21223 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

P.O. Box 68760,

Division of Vital Records,

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Veai Month 10 2010 11:00a CHARLES Α. DORSEY February 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 2501 W LANVALE STREET BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 213-72-5201 MARYLAND Oct. 5 1957 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No MARYLAND N/A BALTIMORE 10e. Street and Number 10g, Citizen of What Country? 10f Zin Code 2501 W. LANVALE STREET 21215 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Black. White, etc 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade METAL PLATER Al PLATING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LEE WILSON JOAN DORSEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jackie V. Wilson/Sister 345 Shagbark Rd., Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02-18-10 METRO CREMATORY BALTIMORE, MARYLAND 21. Signature of Fundation and a great censes WILLIAM C BROWN COMM FUNERAL HOME P.A. Lallen 1206 W NORTH AVENUE Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) oronary avtery disease Due to (or as a consequence of): pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last us to for as a consequence of) Stroke Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? insuffiency 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a Was an

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a State

Funeral

Director

ir than "natural", or items 23a or 28a-f show The Madical Experience must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, Ire Medical Exercit or must

Director

Funeral

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Completed

Be

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with the Maryland

21215-0036

Baltimore, Maryland

burial-tran

attending physician for use as the burla been signed by the should be detached has To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

The law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

Attending Physician;

Examiner Physician/Medical Completed Be ဥ Certification:

Medical

29a. Certifier

23b. Was decedent pregnant in the past 12 months? I ☐Yes 2 ☐ No 9 HInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

erardson km 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 4340 Park Heights the Balton MD 31. Date filed (Month, Day, Year)

State Registrar

FEB 19 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Concetta A. Duffy 2010 5:30 A M February Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Country) 1 □ M 2 💢 🗶 Months Hours Min Director 213-26-6588 Nov 4 1930 MD Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at Director MD N/A Baltimore XX Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1407 Roland Heights Avenue 21211 U.S.A. items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces .0 Black, White, etc ģ 1 Never Married 2 Married 1 Yes 2 XX Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: 3 ₩Widowed 4 □ Divorced Specify: White "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker unknown 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Joseph Detorie Margaret Dinunzio other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Duffy (Son) 2825 Beechland Avenue Balto, MD21214 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 13 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley 2/22/2010 Timonium, MD 21. Signat re of Funeral Servi 22. Name and Address of Facility Burgee-Henss-Seitz Funeral 3631 Falls Road Balto, MD ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Varian Physician/ Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause (Disease or iinjury Due to (or as a consequence of) sician and burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Live Birth
4 Pregnant a
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ Unknown 0.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 W Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perforn certificate Yes Division of Vital or Attending Physician: filled in by the funeral director, 25. Was case referred to medica To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: A Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined To the Hospital o within 24 hours aff To the Funeral Di completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 18 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day Year)

6701 No

Charles St

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#30perDVR G900 2/19/2010 WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 9:53 Dawminnick Felomocur 15 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Hospita west BAltimore Social Security Number 9. Birthplace (State or Foreign Age (In yrs. last birthday 6. Sex Funeral -1698 Months Days COUNTY 1 M 2 □ F Yrs. **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the IM-Strait Experiment must be retitled at appear. 10d. Inside City Limits 10a. State 10h County 10c. City, Jown or Location Baltimore 1 Yes 2 No Funeral Director loodlawn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 IJSA lownbrook 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) vironmenta lec 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 199ins ၀ ward 19b. Mailing Address (Street and Number or Rural Route Number, City Woodlawn, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Himore, MD 5 ☐ Other (Specify) 4 Donation of Funeral Greene Funeral 1a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a const. Lance of): Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 Probably 4 ☐ Unknown 2 🗌 No 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 \sum Yes 2 \sum No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Xio Hospital: 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifie tX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0 15, 2010 40055644 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Northwest Hospital 5401 01d Court Rd. Randallstown, MD 21133 Jennifer Yorke 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month February Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner maryland rs. last birthday) of Birth Social Security Number If Under 24 Hrs . Date 9. Birthplace (State or Foreign Country) **Funeral** 215-22-5168 8 Months Hours 1**X** M 2 □ F 9 2 2 2 19 28 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 No MD10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Apt Funeral 21217 1108 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 No Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ️ No Specify: If Yes, Give Klac 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry DO NOT use ref College (1-4 or 5+) Mday (0-12) ransporta Be 17. Father's Name (First, Middle, Last, ၉ or Rural Route Number, City or Town, State, Zip Code) 21217 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Maurial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) remetery, c 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ disease or condition resulting in death) dro Medical Due to (or as a consequence of) Examiner Respuiset Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a nsequence of) spital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death' **Director:** After this certificate It in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?

1 Yes 2 🔲 No Other: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending work? 2 🗀 No Investigation
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Lettifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6431617 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b, perFH, G900, 2/19/2010, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 20 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4 -a Medical Facility Name (if n institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Deal mo 7. Age (In yrs last birthday Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Days Min. Months Hours Yrs Director Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a State 10h Count 10c. City, Town or Location must be notified at 10d. Inside City Limits Funeral Director 1 Yes 2 No 6 10e. Stre and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a a items 11. Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. 14. Race - American Indian, Armed Forces?/
1 ☐ Yes 2 ☑ No Completed by Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ res If Yes, Give 1 ☐ Yes 2 ☑ No Specify. Specify: 3 Widowed 4 Divorced lac Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary Seconday (0-12) e (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ 19a, Informant's Name Relationship (Type, Print) Ster 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 2010 4 Donation 5 Other (Specify) ansolowne 00 Signatur of Funeral Service Lice 22 Name and Address of Facility 2 Funeral Home, P.A. Ave ofth salto 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical a consequence of Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): attending physician and for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): cal To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 Physician/Medi IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year signed by the a Unknown 9 Unknown P.O. Paryth Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, cate has been siç , page 2 should b 1 🗌 Yes Completed 2 No 3 Probably **U**nknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 Other: Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Durch Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural Accident injury 5 Pending Investigation М Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Mediçal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only o 29b. Signa e of c 29c. License numbe 29d. Date signed (Month, ame and add of person who completed cause of death (tem 23a) (Type Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 09 5.00 PM Doustar 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) , 4b. City, Town, or Location of Death Examiner Catonsville Baltimore Nursing Home If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**K** M 2 □ F Feb 19, 214-77-1810 Director 85 1924 Iran Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show MD Baltimore Director Baltimore 1 ☐Yes 21 No notified 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with a or 23a 21030 USA 1021 Charington Rd. "natural", or Items 23s Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2√ No 3altimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 🖾 No Specify þ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than the M College (1-4or 5+) Elementary/Secondary (0-12) 12 carpenter 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othen any injury or other traumatic event 17. Father's Name (First, Middle, Last) Atealh Doustdar Mahindokht Vakili 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryann Dostdar/daughter 10121 Charington Rd.; Cockeysville, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4⊠Donation 5 □ Other (Specify) 21. Signature 1 Funeral S S. Wade 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C Final disease or condition resulting in death) **Physician** heimos 1 /Medical Due to (or as a conse unce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? for Month Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by signe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy page 1□ Yes Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 5 Pending investigation Injury 1 Natural 1 Tes 2 No 2 Accident hours after death uneral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) within 24 and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) may Miller DA7683 15/10

State Registrar

Vin

31_ Date filed (Month, Day, Year)

Raymora

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Smith

Ave

32. Registrar's Signature

DHMH 17 Rev 1/2001

Srute 200

Balmer MD

21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G901 3/12/2010 III of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2010 DONALD ERWIN EASTMAN 7:00A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death None 2911 Guilford Avenue Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign XX M 2 D F Hours Min Aud Month, Pay, Y13926 Maine 007-18-5937 83 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Director 1**X**Yes 2 □ No Maryland None Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2911 Guilford Avenue 21218 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 M Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🕅 No SpecifyWhite 3 Widowed 4 Divorced "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Automobile Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ora Roland Eastman Myrtle Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GrSon 2911 Guilford Avenue Baltimore, Maryland 21218 Christopher B Eastman Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Mar.09.2010 1 XXBurial 2 Cremation 3 Removal from State Maryland National Mem Pk "UNK. Laurel, Maryland Donation 5 ☐ Other (Specify) nature of Funeral 22. Name and Address of Fac Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease or complication shock, or heart failure. List only one cays that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ denocaranoma yvs. disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of) If any leading to immedicause. Enter Underlying Exam Cause (Disease or iinjury that initiated events that the death certificate be executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 2 No g 🗌 Unknown P.O. I Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 AProbably 4 ☐ Unknown Completed 1 Yes 2 🗌 No Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Residence 6 Other (Specify, ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending within 24 hours after death

To the Funeral Director: /
completed filled in by the f _ Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and Aitle of certifie 29d. Date signed (Month, Day, Year) 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Betsy A Fay 3730 Falls Road Baltimore, Maryland 21211 31. Date filed (Month, Day, Year) 32/Registrar's Signature State FEB19 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 04475 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Per ua Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** 4c. County of Death Washington County Hospital Washington Hagerstown 5. Social Security Numbeunk If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year Director ept <u>Pennsylvania</u> Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Washington Williamsport 1 Yes 2 No 10e. Street and Number 36 N. Conococheague St. 10g. Citizen of What Country? ò 10f. Zip Code 21795 or than "natural", or items 23a or the Medical Examiner must be Funeral 12. Was Decedent Ever in U.S. Armed Forces?Unk 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 white 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other transmitted. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) disabled none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Darlington Eyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14838 National Pike; Clear Spring, MD 21722 Joseph Eyler/son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 3 ☐ Other (Specify) In State cemetery, crematory or other place) 21. Signature of Funeral Service License Bonald S. Way State Anatomy Board; 655 W. Baltimore Street 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock or heart failure. List only one caus, on each line. Approximate Interval Between Immediate Cause (Final Pnysician disease or condition Medical resulting in death) ue to (or as a conse uence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) -transit and Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical that the death certificate be Box 68760 attending philor use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 □ No 9 Unknown 9 Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should ALETHS MERCITU 24b. Were autopsy findings available 24a, Was an certificate has autopsy prior to completion of cause of death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 XNo Hospital ၉ 1 Yes 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral dir . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred the Hospital or Attending work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State, Medical 29a. Certifier 1 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. n who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar (Month, Day

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

MEND #19B PER ANA BD G901 3/10/2010 IIII
State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Ellis **Physician** 930 AM Joseph 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Berlin Hospital General WUrcester If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. Aug 8, 1936 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1 X M 2 □ F 449-46-4577 73 Texas Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, If a Madical Examiner must be notified at Worcester Ocean City 1 ☐ Yes X☐ No Director Maryland 21215-0036 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 104A 120th St. Unit 409 21842 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No 1956—
If Yes, Give Year or Dates: 1959 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married white 1 □Yes 2X No Specify. 3 Widowed 4 Divorced 1959 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) Ilmore, ...
It. Pages 1 and 2 should be filed within 72.

Health and Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Pers. Ofcr. Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, It once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Otis Ellis Lera Ruth Evans ည 19b. Mailing Astronomy and Number or Rural Route Number, City or Town, State, Zip Code) 6902 SEankerr Dr.: Burke. VA 22015 19a. Informant's Name/Relationship (Type. Print) Fr Dr.; Burke, VA 22015 Maria Ellis/wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) State Anatomy Board; 655 W. Baltimore Street 21. Signature of Eun erwice Licenses frector Baltimore, Maryland 21201 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca ce (Final disease or condition resulting in death) Metartatic CA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed and Due to (or as a consequence of): 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Ö ieral Director; After this certificate has been signed by filled in by the funeral director, page 2 should be detact σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 1 X Yes 2 No 3 Probably 4 Unknown 1090 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐No Division of Vital or Attending Physician: after death. Director; After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Marient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and tiple of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20062130 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Berlin, MD 21811 Healthway Dr. 9733 31. Date filed (Month, Day, Year) ,32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

10-00836		Please Type or Print in Black Indelible			ible.			
Joseph Louis F	orem	State of Maryland / Department - For State Certificate			2010 0447			
Physici	an/	Decedent's Name (First, Middle,Last)	or Death	2. Date of Death	3. Time of Death			
Medical Exam		JOSEPH LOUIS FOREMAN		Month I January 29,	2010 Year 1400 hrs			
		Facility Name (if not institution, give street and number) Road	4b. City, Town, or Location of Dea Frederick	th	4c. County of Death Frederick			
Funeral	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		rs. 8. Date of Birth	(MM/DD/YYYY) 9. Birthplace (State or			
Director		212-38-7699 1/m 20F 69	Months Days Hours Mi	n. FtB 8	1940 Foreign Country) M.D.			
		Usual Residence of Decedent		,	, , , , , , , , , , , , , , , , , , , ,			
ow any		10a. State 10b. County 10c. City, Town or Lot FROORICK FROOR			10d. Inside City Limits 1 Yes 2 No			
Aaryland 28a-f show 1 at once,	ctor	10e. Street and Number	10f. Zip Code	100	. Citizen of What Country?			
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Director	208 Phebus Ave Apt 208			USA			
ms 23.	Funeral		Vas Decedent of Hispanic Origin? () f Yes, specify Cuban, Mexican, Puerl		14. Race - American Indian, Black, White, etc.			
	Fun	1 Yes 2 No		to Alcan, etc.)	Specify: BLACK			
ırs afte ural", miner	by	or Dates:	Yes 2 No specify: lent's Usual Decupation (Give kind of	f work done	Specify: 6b. Kind of Business/Industry			
72 hou n "nat	etec	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use re	etired)	MO. STATE			
DO36 within iene. eer tha	Completed		BORER		ROADS			
Baltimore, MD 21215-0036 bermit Pages I and 2 should be filed within 72 hours after death with the Maryland obpartment of Health and Mornell Hygiens in Mornel Hygiens in the Maryland important: If item 23 is marked other than "natural", or items 23a or 28a-f she niprry or other traumatic event, the Medical Examiner must be notified at once	Be Co	17. Father's Name (First, Middle, Last) TOSEPH R. FOREMAN SR.		ne (First, Middle, Ma				
D 21 should be and Mer	To	19a. Informant's Name/Relationship (Type, Print)	ing Address (Street and Number or	Rural Route Numb	er, City or Town, State, Zip Code) OERICK MD 2(70)			
and 2 sealth a tem 27		20a. Method of Disposition 20b. Place of Disp	osition (Name of cemetery,		20c. Location - City or Town, State			
imore, Pages 1 an nent of Hea ant: If ite		Burial 2 Cremation 3 Removal from State crematory or	other place) Con. ZGR UMC FC	9 2010	JAMSVICCE MO.			
Baltin permit. P. Departme Importan injury or		4 Donation 5 Other Specify: 21. Signature of Funeral Service Ligensee 2	. Name and Address of Facility	A1 V /	ROLLINS FUN ITOME			
Dep Dep Inju		100000	U WUSI 300411.	SITER	Cation on on			
Physician / /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not ente failure. List only one cause on each line.	r the mode of dying, such as cardiac	or respiratory arres	Between Onset and			
Examiner		Immediate Cause (Final disease or condition resulting in death) a Smpke Inhalation Due to (or as a consequence of):			Death			
		Sequentially list conditions, b.						
	iner	if any, leading to immediate Due to (or as a consequence of):						
E	Examiner	(Disease or injury that initiated events resulting in death) Last Use to (or as a consequence of):						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after dear. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	ᇹ	d						
30, te be e sysician burial	ledic	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery			
Box 68760, e death certificate be excite attending physician ed for use as the burial.	Physician/Medic	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregr	nancy	Month Day Year			
OX (eath ce attence for use	sici	1 Yes 2 No 9 Unknown g Unknown	Other (Specify)					
O. BG at the des		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?			
Division of Vital Records, P.O. talor Attending Physician: The law requires that the all Directors. After this certificate has been signed by led in by the funeral director, page 2 should be detach.	d by			1 Yes	2 No 3 Probably 4 Unknown			
cords,	Completed			24a. Was an autopsy				
Recc The lav cate ha	E O			perform 1 Yes 2				
ital Re(ician: The secrificate rector, page	BeC	25. Was case referred to medical examiner?	26.Place of Death (Check	only one)				
of Vit ing Physic After this cuneral dire	유	1 Yes 2 No No Inpatient 2 ER/Outpatie		ing Home 5 Re	esidence 6 🗹 Other: Scene			
on of 'nding Ph. : After t	Certification:	1 Natural 5 Pending FOUND: FOUND:	1 Yes 2 ✓ No	accidental res				
ivisior or Attend after death Director:	ficat	2 Accident Investigation Jan 29, 2010 1350 hrs 28e Place of Injury - At home farm street factory office building etc. 28f Location (Street and Number of Run						
Divis Bospital or A 24 hours after Funeral Bire	erti	Suicide Suicide Getermined Specify) Multi-Family Apt.		or Town, Stat 208 Phebus Roa	te) ad, Frederick, MD			
Di To the Hospital within 24 hours a To the Funeral I completely filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurrence one) 2 Medical Examiner: On the basis of examination and/or investign.			-			
To th vithin comp	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)			
		Should Mark	O.C.M.E.		January 30, 2010			
		30. Name and address of person who completed cause of death (Item 23a)						
			11 Penn Street, Baltimore,	MD 21201				
S	tate	31 Date filed (Month, Day, Year) 22. Registrar's Signature	Les de la company de la compan					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Day 4, 2010 5:32 PM On Medical 4a. Facility Name (if not institution, give street and number, 212 Lloyd Street Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore 1944 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 □ M 2**X X** F Days Hours Min. Oct 312, 1934 216-44-4646 75 Yrs 65 **Director** Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD N/A Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21202 USA 212 Lloyd Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes XX No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Segonday (0-12) College (1-4 or 5+) Insurance Claims Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Brown Joseph Samuels Fonte Margaret Louise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 28 Tully Cross Court Timonium, MD 21093 Department of Health ar Important: If item 27 is any injury or other trauonce. Rhonda Fonte / Niece Baltimore, 20a. Method of Disposition
1

Burial 2

Cremation 3

Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 2/18/2010 Towson, Maryland Hilltop Serv. Corp. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility TOWSON, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) onfishe Medical Examiner Sequentially list conditions Examine cause (Disease or iinjury Due to (or as a consequence of): -transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Dav Year 1 Yes 2 9 Unknown ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 Ao 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law autopsy performed' 1 ☐ Yes 2 No 1 Yes 2 W 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 146 ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Tyes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Wu 1600 S. Crain Huy Ste 106, Galen Burnie, Mb 21061 31. Date filed (Month, Day, Year) State Registrar FER 19 2010

ToD

2/14/2010

DoD

Fonte

Dorothy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of IVI	aryiand		artment of I tificate of I			ental Hy	/gier Reg. 1	20	10	nl	1470
	Physici	an/	1. Decedent's Name (First, Mid								2. Date of D	eath		V	3. Time	of Death
	Medi	cal	Rosalie	Flyn						:	Month Februa	ry	Day 06 2	Year 010	05:	40 A ^M
	Exami	ner	4a. Facility Name (if not institution, give street and number) Stella Maris Hospice 4b. City, Town, or Location of Death Timonium B													
	Funeral		5. Social Security Number	6. Sex		(In vrs. las	st birthday)	If Under 1 Year		er 24 Hrs.	8. Date of Bi	rth	В	alti:		e or Foreign
	Director		220-32-3251	1 🗆 N	/1 2 ☑ F		71 Yrs.	Months Days	Hours		(Month, D. March	ay, Year 03	1938	Coun	ntry) MD	
	d tow] _	Usual Residence of Decedent 10a. State 10b. Cour	tv		10= 0%	Town on La									
	arylar a-fst fied	읂				Tuc. City,	Town or Lo							1		City Limits
	or 28	ä	Maryland 10e. Street and Number	N/A				10f. Zip Code	Balti	imore		100	- Citizen of W	/hat Caua		es 2 🗆 No
	with t	Funeral Director	3838 Roland A	venue					2121	1		Tog.		USA	luyr	
	death item; ier m	臣	11. Marital Status	12.	Was Decedent E Armed Forces?	ver in U.S.	13.	Was Decedent of H f Yes, specify Cuba	lispanic O	rigin? (Spec	ify Yes or No	-	14. Race	- Americ	an Indian,	
5:40 a.m 215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	1 ☐ Never Married 2 ☐ M 3 ☐ Widowed 4 ☒ Divorc	ed	1 ☐ Yes 2 🔀 I If Yes, Give Year or Dates.	No		Yes 212 No			rcan, etc.)		Specify:	k, White, 6	_{etc.} hite	
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5:212	within giene.		Elementary/Seconday (0-12)	College (1-4 or 5-	+)	lite. D	O <i>NOT use retired)</i> Homemak					Нои	seho	.1.2	
	filed val Hyg d othe	Be	17. Father's Name (First, Middle	, Last)				110memax		her's Name	(First, Middle,	, Maide			10	
2010 yland	d be Menta	은	Max Peter	zak					Ма	ry	Unkn	own				
6, 2010 Maryland	should be and Me		19a. Informant's Name/Relation	nship <i>(Type</i> ,	Print)		19b. Mailir	g Address (Street	and Numb	per or Rural	Route Numbe	er, City	or Town, Sta	ate, Zip C	ode)	
	and 2 Health em 27 ther tr		Rose Mary Murr 20a. Method of Disposition	ay (d	daughter			Firewood	l Cou	ırt, J	essup,					
FEBRUARY Baltimore,	Page 1 anent of Pant: If its		1 Burial 2 K Crematic	n 3 🗌 Ren	noval from State	cer	metery, cren	sition (Name of natory or other plac	ce)	Feb. 20	16		Location - 0	•		
BRU	artme artme ortani injury		4 ☐ Donation 5 ☐ Other 21. Sign une of -un : Service	_	\wedge	Meti		matory I					timor			
FE Ba	permit. Departr Imports any inju		21. Signature of Parising Service	X	()			. Name and Addres 3 111 Mour		Road	tallir , Pasa	igs dena	runer a, MD	2112	ome, 22	P. A .
			23a. Part 1. Enter the disease, shock, or heart failure. Lis	or complica	tions that caused	the death.									Approxima	
	ęnysician/		Immediate Cause (Final disease or condition	comy onage	LUNG CA									1	Interval Be Onset and	
	Medical Examiner		resulting in death)	a	Due to (or as a		nce of):									
		ē	Sequentially list conditions,	b. =	Don't de la company									_		
, Š	ed sit	Ē	if any, leading to immediate cause. Enter Underlying	<	Due to (or as a	conseque	nce ot):							1,1		
(Ja)	executed an and rial-transi	Examiner	that initiated events resulting in death) Last	C	Due to (or as a	conseque	nce of):							+		
0	icate be executed griphysician and sthe burial-transit	lical		L d.												
8760	tificat ng ph as th	Med	IF FEMALE:	_												
× 66	eath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?	1		☐ Fetal o	death 3	Ectopic pregnance	у				23d. Date			
FLYNN P.O. Box	requires that the death certificate be. been signed by the attending physicis should be detached for use as the bur	by Physician/Medical	1 Yes 2 X No 9 Unknown		4 Pregnant at 9 Unknown	time of dea	ath 5 L	Other (specify)					Mont	th	Day	Year
	that the ped be deta	oy P	Part II. Other significant condi-	tions contrib	outing to death but	t not result	ting in the ur	nderlying cause giv	en in Part	l.	23e. Did to	obacco	use contrib	oute to the	e cause of	death?
ROEALIE Records,	quires en sig ould b	ted									1 🗆	Yes 2	2 □ No 3	Prob	ably 4	Unknown
EA	aw reas be	Completed									24a. Was		24b. We	ere autop	sy findings	available
-	The I	Con										rmed?	de	ath?		oddsc of
Vital	ician: certifii ector,	Be	25. Was case referred to medica examiner?	l Hosp	ital:					ath (Check o	nly one)					
<u></u>	Phys	2	1 Yes 2 X No 27. Manner of Death		1 Inpatier		R/Outpatient	3 DOA Othe	_ 4 ⊔ N		5 🗆 Resid				HOSP	1CE_
Division of	Attending Physician: or death. ector: After this certific by the funeral director,	Certificate:	1 X Natural 5 Pend		(Month, Day,	Year)	injury	work'	at ? Yes 2.⊑	- 1	d. Describe h	iow inju	ry occurred			
isic	Atter er dez ector by th	ij.	3 Suicide 6 Coul	t not be	8e. Place of Injury	/ - At home	e, farm, stre			-	f. Location (S	Street ai	nd Number	or Rural F	Route Num	iber,
<u>5</u>	ital or urs aft ral Dir lled in		\		building, etc.						City or Tow					
	To the Hospital or Attending Physician: The law requires that the der within 24 hours after death. To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached.	Medical	(Check 2 L Medical	Examiner: (On the basis of exa	mination a	nd/or investi	ccured at the time, gation, in my opinion eath occurred at the	n, death o	ccurred at th	e time date a	nd place	a and due to	o the cour	ea(e) and m	anner stated.
	To the within To the COMP		29b. Signature and title of certific		actiones. To the be	7	nowledge, di	29c. License		and place,			s) and manr ate signed (
	•		19/10	UD	CANP			KIL	197	92			2/8/	20/	0	
	\		30. Name and address of person			ith (Item 23	3a) (Type, Pr						, ,			
	Stat	e_	JACKIE JONES, 31. Date filed (Month, Day, Year)	CRNP	2300 DU			EY RD.	LIMON	ITUM,	MD 210	93				_
	Registra		EED 199	010	But .	1	back	2			_					
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month FISCHER 0726 AM FEBR 2010 Medical All 4a. Facility Name (if not institution, give street and number) CENTER **Examiner** 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOALINS RAYVIEW MEDICAL 8. Date of Birth (Month, Day, June 13 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Days 1 M 2 TXF Months Min. Mary land Director 219-30-2935 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location aţ 10d. Inside City Limits the Maryland Director or 28a-f sl notified Baltimore Dundalk 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Examiner must be 23a Funeral 21222 **USA** 7809 Kavanagh Road death with items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian. Or 1 Never Married 2 X Married should be filed within 72 hours after or and Mental Hygiene. Completed by 1 Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Waitress Restaurant item 27 is marked othe other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lydia Messner Frank Sparrow 19a. Informant's Name/Relationship (Type, Print) .. Page 1 and 2 shou tment of Health and tant; If item 27 is m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7809 Kavanagh Road, Dundalk, Maryland 21222 James L. Fischer Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of H February 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Important; If any injury or Meadowridge Halethorpe, Maryland 22, 2010 Signature of Funeral Service Licensee Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Denot enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ ELECTRICAL ACTIVIT PULSELESS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CARDIOVASC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence on death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregpant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Month the detached 9 Unknown P.O. Physician: The law requires that the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à director, page 2 should be Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No မ 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA this in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After To the Hospital or Attending Natural 5 Pending 1 Yes 2 No Investigation Could not be Accident within 24 hours after deat To the Funeral Director. 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотрыеть Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 1)0067369 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21224

Registrar

State

4940 EASTERN AVENUE

TAD-Y

MD

32. Registrar's Signature

BARLENE

31. Date filed (Month, Day, Year) **FEB 19 2010**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 **Physician** FARRIS CORA 03:10AM FEB /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Howard County Columbia If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State o Country)
October17,1928Freeman, Va. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 216-28-2264 81 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County th and Mental Hygiene. ?7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, I'm Widical Examble, must be notified at 1 □Yes 2□No Directo Baltimore Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6513 Woodgreen Circle 21207 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 💆 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Black Specify: 2 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Telephone Company Telephone Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarence Williams Sarah B. Franklin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important; if Item 27 is any injury or other trau once. 6513 Woodgreen Circle Baltimore, Maryland 21207 Ametha L. Dunigan / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Pineview Cemetery 2-20-2010 Rocky Mount, N.C. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshalls Funeral Home, Inc of Funeral Service Licensee 4308 Suitland Road Suitland, Maryland 20746 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final INTRACEREBRAL **Physician** disease or condition resulting in death) Due to (or as a consequence of): INTERVENTRICULAR BLEEDING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner SENILE that initiated events resulting in death) Last Due to (or as a consequence of) DEPRESSION Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 Tyes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 PERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 □ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2-☐ No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

/Medical Examiner the death certificate be P.O. of Vital Records. To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir this Division To the within 2

attending physician and for use as the burial-transit signed by the a Certification: To

Medical

State Registrar

show

with

Pages 1 and 2 should be filed within 72 hours after death

Saltimore, Maryland 21215-0036

29a. Certifier

(Check only one)

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of

PHYSICIAN

29c. License number 0062704

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Swife 100, ELL" COH GHY, MD 21043 Ridge Road

and manner stated.

31. Date filed (Month, Day, Year)



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17,18&19a Per FH C900 2/24/2010 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death February Physician/ Day Glinowiecki Joseph 201 05:14 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Johns Hopkins Bayview Medical Ce N/A nter Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 7, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1XXM 2 □ Months Maryland Director 219-22-1195 June 81 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Dunda1k Baltimore 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 United States 1719 Melbourne Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Specify: White Year or Dates. Korean 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done duning most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Years Painter Steel Industry 12 Be 18. Mother's Name (First Wirds Maiders Kname) 17. Father's Name (First, Middle, Last) ျ Mary Anna Wi Stanislaw Glinowiecki 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Carolyn A. Glinowiecki 21222 1719 Melbourne Road Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗀 Cremation 3 🗀 Removal from State 2/16/2010 Sagred Ht. of Jesus Cem. Dundalk, MD 4 ☐ Donation 5 ☐ Other (Specify) Synature 2. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, uneral S Inc. 21222 7922 Wise Ave. Dundalk, 23a. Part 1. Enter the disease, or complications that caused ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1 UCC K Immediate Cause (Final Ph_sician/ PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury has been signed by the attending physician and as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death for use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnation 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Yes 2 No Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe Director: After this certificate 1 Yes 2 No 21 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 - ER/Outpatient 3 - DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Accident 3 Suicide 4 Homicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after within 24 hours a To the Funeral I Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 ebruary address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue Baltimore MD 21224

Registrar DHMH 17 Rev 7/2009

State

M.D

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dav Year ANTOINETTE GRVKEN 04:05 A M FEBRUAL. Medical 2010 **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, 1 □ M 2 🔯 Days (ear) Maryland Director 87 213-14-2768 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Baltimore City 1XXYes 2 No N/A MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21224-5035 1007 South East Avenue United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Yes 2 No Yes, Give hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: White Specify Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 72 permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important. If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) 8 Years College (1-4 or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Sierak Peter Rostkowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Mr. John Gryken, Sr. 1007 South East Avenue Baltimore, MD 21224-5035 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Entombment Stanislaus Cem! 2/20/2010 Baltimore, Maryland 21. Signature of Funeral Service Licenses Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician, ISCHEMIC STROKE 6 DAYS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or iinjury certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): anding physician a use as the burial. Physician/Medical Box 68760° IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No ò Day Month Year Pregnant at time of death the i P.O. ed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Division of Vital Records, Completed 1 ☐ Yes 2 12 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' 2 🗌 No 2 N To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 2 No ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director; After t completed filled in by the funera 28d. Describe how injury occurred 1 🗹 Natural 5 Pending injury 1 Tyes 2 🗆 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number relissad moroar RES-000 FEBRUARY 15,2010

State Registrar 4940 EASTERN AVENUE

BALT IMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MORGAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Frances Rochelle Gales 2010 1:15 p. M Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death 3408 West Ropers Avenue 5. Social Security Number 6. Sex Baltimore 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛛 F Months Hours Min. (1075) Pto 39 Country) 219-26-8227 Director 70 MD Usual Residence of Decedent "natural", or items 23a or 28a-f sho 10a. State 10b, County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD Baltimore n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3408 west Rogers Avenue 21215 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes : 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: African-American Completed 3 Widowed 4 Divorced Year or Dates : If item 27 is marked other than "natur or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Assistant Manager Balto. City Housing Authorit Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Cooper Nora Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annette P. Harrell/daughter 3408 West Rogers Avenue, Baltimore MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 🕅 Burial 2 🗆 Cremation 3 🗀 Removal from State 2-22-2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licenses 22. Name and Address of Facility White Funeral 9200 Liberty Road, Randallstown, 1 l Home P.A. of Balto. Co. 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Colon disease or condition resulting in death) cancer Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine or Attending Physician: The law requires that the death certificate be executed per tenson ed by the attending physician and detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4 Pregnant a Month Day Year 5 Other (specify) Pregnant at time of death cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 🗆 only one) 29b. Signature and title of certified 29d, Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

altimore

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 17, 2010 12:47 A Physician Helen Agnes Guerin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Edenwald **Baltimore** Towson
If Under 1 Year 5. Social Security Number If Under 24 Hrs. 8. Date of Birth 7 / 20 / 19 19 Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1□ M 2√√ F Davs Hours Min. Months Pennsylvania 90 054-03-0207 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If them 27 is marked other than "natural", or them: 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 USA 800 Southerly Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: White 2 3 X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Assistant Elementary/Secondary (0-12) College (1-4or 5+) Administrative Book keeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Agnes Palmer Charles Shepard ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B. Singman / Friend 800 Southerly Road Unit 1201 Towson, MD 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ NBurial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. 2/20/2010 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Towson, Mary land 121204
Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death such as cardiac or respiratory Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE yes, outcome of pregnancy
Live birth 2 🗆 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Name of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of ersor

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day

1 - For State Registrar

	Physici	an	1. Decedent's Nar	ne (First, Middle, L	ast)					Date of Dea Month	ath Day	Year	3. Time of Death
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	Funeral Director		314-30-7	7193	1 ∑ M 2□ F	77	117004/	Days	Hours Min.	8. Date of Birt 11-10	32 (2)	Cou	place (State or Foreigntry) IN
	yland how		10a. State	10b. County		10c. City, Towr	or Location					1	10d. Inside City Limit
:	a-fsl	ctor	MD	BALTIMO	RE	F	ESSEX						1 X Yes 2 □ No
:	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, I'm Michel Ezari increment the matthe	al Director	10e. Street and Number #4 FORE CT.				10f. Zip C	ode 1221			10g. Citize	n of What Cour	ntry?
	ems deat	Funeral	11. Marital Status	-	12. Was Decedent Armed Forces		13. Was Deceder	nt of Hisp	panic Origin? (Spe Mexican, Puerto F	cify Yes or No-	14.	Race - Americ	can Indian,
0000	ours after all', or it Evarrin	ρ	1 ☐ Never Mai 3 ☐ Widowed	ried 2 Married 4 Divorced	1 Tyes 2 ☐ If Yes, Give Year or Dates:	No					i	Black, White, Decify: BLA (
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7 2	2 should be I n and Mental Is marked o raumatic eve	ဥ	JOHN	GARDNE	R				GLADY	S SH	OOK		
3	2 sho			lame/Relationship		19b.	Mailing Address (5				-	own, State, Zip	Code)
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5	Pages 1 nent of H int: If ite iry or ot		20a. Method of Dis	•	Removal from State	20b. Place of cemeter	Disposition (Name y, crematory or other	of er place)	Da	ate	20c. Loca	tion - City or To	own, State
	rtmer rtmer rtant:				Removal from State fy)	CROW	NSVILLE V		02/25	/2010	CROW	NSVILLE	E, VA
	permit. Pages Department of Important: If it any injury or one		21. Sign ture of F	uneral Service Lice	nsee WA +		22. Name and	Address	of Facility JAME	S A. M	ORTON	& SONS	F.H., INC
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			shock, or he	art failure. List only	plications that cause one cause on each li	ne.			such as cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
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Physician	certificate ector, pag	Be (25. Was case refe examiner?	rred to medical				2	6. Place of Death	1			
hvs	this c	P,	1 Yes 2				tpatient 3 DOA	Other:	4 ☐ Nursing Hom	e 5 🗆 Resid	ence 6	Other (Specif	<i>(y)</i>
na	After	Ö	27. Manner of Dea 1 Natural	5 Pending	28a. Date of Inju (Month, Da	ıry 28b. T <i>y, Year)</i> Ir	njury	Injury a Work?	t 28	3d. Describe h	ow injury o	ccurred	
tend	tor: the f	cat	2 ☐ Accident 3 ☐ Suicide	investigatio 6 ☐ Could not b			М		s 2 No				
or A	offer of Direction by	Certification:	4 ☐ Homicide	determined	28e. Place of Inj building, et	ury - At home, far c. <i>(Sp</i> ec <i>ify)</i>	m, street, factory, o	fice	28	If. Location (S City or Tow	treet and N n, State)	lumber or Rura	al Route Number,
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e Hos	within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only one)	2☐ Medical Exa	nysiclan: To the best miner: On the basis of and manner st	f examination and	d/or investigation, in	my opin	ion, death occurre	d at the time, o	date and pla	ace, and due to	stated. the cause(s)
To th	Vithin Somp	₩.	29b. Signature and	I title of certifier	0 1		29c. L	icense n	umber	2	29d. Date s	igned (Month,	Day, Year)
)	Kinjalo	Sing !	, MCD	RE	ESC	00000		D	2/18	12010
,		-	30. Name and add	ress of person who	completed cause of c	leath (Item 23a) (6.3.3	. 1	
			Ang	alt S	ingh N	D 900	o Frank	lin	Square	Dr Ba	Itim	nore, M	D 21237
	Sta	te	31. Date filed (Mor	B 1 9 201	3. Registr	ar's Signature	Land						
	Registra	ar	11	"D T O ZOI	U KARA COUR	1 p. 19	parker						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 20 | 0

Reg. No.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ -REQUARY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death 4c. County of Death TMOR . Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 ₹ F 80 Months Hours Sept. Day Year 929 213-26-1465 Maryland Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merdal Hygiene. Important: If tier 27 is ma Merdal other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Baltimore County 1 Yes XX No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2901 Andorra Ct. Apt. C 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 🎗 🛣 No Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2xxNo Specify: 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore County 12 VIS (0-12) College (1-4 or 5+) School Bus Driver Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Walton Larkins Ada Elizabeth Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 412 Edmund St. Aberdeen, Md. 21001 David W. Gayle (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Metro Crematory, Inc. 1 Burial 2XXCremation 3 Removal from State 2-17-2010 Baltimore, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee ²²Lassanderfyferal Home 7401 Belair Rd. Baltimore, M Md. 21236 23a. Part 1. Enter the discusse, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on ea Immediate Cause (Final Physician/ Medical resulting in death) consequence of): Examiner Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami the Hospital or Attending Physician: The law requires that the death certificate be executed the 24 hours after death. The Funeral Director. After this certificate has been signed by the attending physician and implied filled in by the Inneral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 2 🔀 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending work?
1 Yes 2 Accident
3 Suicide
4 Homicide Investigation 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) of certif 29b. Signature and title 29c. License number

Registrar

31. Date filed (Month, Day, Year)

FEB 19 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch Raven Blad Duttey Pinelis Baltimore, MD 21239 32. Registrar's Signature

D63382

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore of man land If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 219-32-9126 1 □ M 2 🗙 F Months Days Hours Min. Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Medical Examiner must be netified at 10c. City, Town or Location Director 10d. Inside City Limits MD Yes 2 No 10e. Street and Number ò 10f. Zin Code 10g. Citizen of What Funeral 23a items 72 hours after death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc of Health and Mental Hygiene. item 27 is marked other than "natural", or other traumatic event, the Medical Examin δ 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 Yes If Yes, Give Year or Dates 1 ☐ Yes 2 WNo Specify: Blac Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working onday (0-12) College (1-4 or 5+) Be permit. Page 1 and 2 should be file.
Department of Health and Mental Hv.
Important: If item 27 is martany injury or other? Father's Name (First, Middle, Last, 19b. Mailing ural Route Numbe 20b. Place of Disposition (Name of cemetery, crematory scotter place)

Baltimore Ceme 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequent of): disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No detached for Month Day 9 Unknown þ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ page 2 should be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 Yes To the Funeral Director: After this certific completed filled in by the funeral director, To Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) MD FINUA and address of person who completed cause of death (Item 23a) (Type, Print) Gree 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

10-01323 Alan Goldman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificat	e of Death	Reg	201L 1. No.	04483
Physicia	an/	1. Decedent's Name (First, Middle,Last) Alan Joseph Goldman		Date of Death Month	Day Year	3. Time of Death 1706 hrs
Medical Exami	ner	3, 2010 4c. County of Death	1700 1115			
		Facility Name (if not institution, give street and number) S00 West University Parkway, Apartment 15M	ac. County of Death Baltimore			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd			(MM/DD/YYYY) 9. Birth Foreign	
Director	1	139-30-2868 1₺M 2□F 77	Yrs. Months Days Hours Min	March 2	2, 1932 co.	ntryNew York
ny	ſ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
T 00 4		MD Baltimore Baltimo				1 X Yes 2 No
Maryland 28a-f show any 1 at once.	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Coun	try?
th the M 23a or 2 notified		500 W. University Pkwy.	21210		USA	
3 72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must he notified at once	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 		14. Race - Americ White, etc.	an Indian, Black,
ter des		1 Yes 2 No 3 X Widowed 4 Divorced If Yes, Give Year	1 Yes 2 No specify:		Specify: Whit	e
2 hours af "natural Examin	d b		cedent's Usual Occupation (Give kind of ring most of working life. DO NOT use re		1 16b. Kind of Business/Ir	-
36 n 72 h isa "n	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	rofessor	ured)	Johns Hopk University	
5-0036 led within 72 Hygiene other than the Medical	E	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	aiden Surname) UNK	
21215-0036 sold be filed within 7 Mental Hygiene. marked other than c event, the Media	Be	Leonard Goldman	Sylvia	Shacter		
D 21215-0036 should be filed within and Mental Hygiene. 7 is marked other tha	욘		Mailing Address (Street and Number or			
, MD and 2 sho ealth and em 27 is		·	3 W. Broad St.; Ap	Date I	20c. Location - City or	
Ore ges 1 a nt of H		Dullar 2 M Cremation 5 L Removal from State	y or other place)	26/2010	Woodbine,	vm.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 77 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumantic event, the Medical	H	21 Signature of Euparal Service Licenters	22 Name and Address of Facility Cha	riceo Wo	ode F/S	
F Per E		Ronal S. Director 23a. Part Enter the disease, of complications that caused the death. Do not	2/00 Edmondeon Ave	B <u>ATCIM</u> A	re; Mb 212	zgtreet
Physician /Medical		failure. List only one cause on each line.		or respiratory arres	st, shock, or heart	Between Onset and
Examiner		Immediate Chiefe (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Due to (or as a consequence of):	r Disease			Death
	Ш	Sequentially list conditions, b				
	iner	if any, leading to immediate Due to (or as a consequence of):				
d sit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
760, icate be executed physician and the burial - transit		d. UNPENDED X AMENDED				
760, icate be of physicia the buria	Medical	If FEMALE: 23c. If yes, outcome of pregnancy	1.g901.2.262010.WS		23d. Date of delivery	
cath certificate be attending physici for use as the buri		23b. Was decedent pregnant in the past 12 months? 1 Live birth 2	Fetal death 3 Ectopic pregr	nancy	Month D	ay Year
Box 68 e death certifi the attending	Physician	1 Yes 2 No 9 Unknown Pregnant at time of death 5	Other (Specify)			
ch de the		Part II. Other significant conditions contributing to death but not resulting it	n the underlying cause given in Part I.		pacco use contribute to t	
S, P,C uires that n signed lid be deta	ed by				2 No 3 Prob	
ords, aw requir as been s	Completed	<u> </u>		24a. Was a autops perform	y prior to c	opsy findings available ompletion of cause of
	힝			1 Yes 2		s 2 No
/ital ysician: nis certi director	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outs	26.Place of Death (Check patient 3 DOA Other,4 Nurs		Residence 6 🗸 Other	Scene
of Vital Records, ng Physician: The law require After this certificate has been si neral director, page 2 should t	일	27. Manner of Death 28a. Date of Injury (Month Pay Year) 28b. Tir	ne of Injury 28c. Injury at Work?		ow injury occurred	
	atio	1 V Natural 5 Pending 2 Accident Investigation	1 Yes 2 No			
Division pital or Attendion ours after death. teral Director. filled in by the fi	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm	n, street, factory, office building, etc.	28f. Location (St or Town, Sta	treet and Number or Ru ate)	ral Route Number, City
D the Hospital hin 24 hours the Funeral		4 Homicide 29a. Certifier Certifier Physician To the heat of my leaved decided.	a occurred at the time, date and place, an	d due to the cause	a(s) and manner as state	ad .
Di To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invariant manner stated.				
5 F M G	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor	• • •
		Calmer T	O.C.M.E.		February 16, 201	0
		30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111	Penn Street, Baltimore, MD 2	1201		
	tate	31 Date filed (Month Day Year) 32 Registrar's Signature	A		·	
Regis		FFR 1 7 2010 June 1. Lan	Kal			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 1616 2010 Feb. RAYE GLASGOW LA-UNA Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Montgomery Silver Spring Holy Cross Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days (Month, Day, Ye 1946 243-76-0233 63 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ms 23a or 28a-f shorms must be notified at **Funeral Director** 1 Yes 2 No Mitchellville Prince Georges MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20721 9406 Kynaston Ct. permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 14 Bace - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Yes 2 No 1 Never Married 2 Married þ 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates **Black** Completed 3 X Widowed 4 Divorced 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Dept. of Treasury Director 12th 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Polly Pearl Cole Doctor Ralph Beasley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mitchellville, Md. 20721 9406 Kynaston Ct. Chandra Kennedy - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 1 🕅 Burial 2 🗌 Cremation 3 🗌 Removal from State 2-18-2010 Arlington, VA. Arlington National 4 Donation 5 Other (Specify) 22 Name and Address of Facility Marshall's Funeral Home of Maryland Signature of Funeral Service License Suitland, Md. 4308 Suitland Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Metastic Endometrial Cancer Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Obstructive Uropathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Urosepsis Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Year Month Day in the past 12 months?

1 Yes 2 XNo g Unknown 9 Unknown Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Division of Vital 25. Was case referred to medica Be Other: 4 \(\sum_{\text{Nursing Home}}\) Nursing Home 5 \(\sum_{\text{Residence}}\) Residence 6 \(\sum_{\text{Other}}\) Other (Specify) 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 1 Tyes 2 🕱 No ပ 28d. Describe how injury occurred 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: iniury 5 Pending X Natural 1 Tes 2 🗌 No ☐ Accident☐ Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0069835 3/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) silver Spring, Md. 1508 Forest Glenn Rd. Sangeetha Ranganath, M.D. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23a, 25 per me, g900,02/18/2010ahb

Certificate of Death

Reg. No. 1 - For Amend Items Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Shelby J. Harrison January 2010 3:00p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Carroll Hospice Dove House Westminster Carrol1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) Aug 28, 19 9. Birthplace (State or Foreign Country)

KY 6. Sex **Funeral** 1 □ M 2 □ F Director 157-30-3890 73 1936 Usual Residence of Decedent death with the Maryland 10b. County 10d. Inside City Limits 10a. State 10c City Town or Location 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director MD Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a7523 Dogwood Road 21784 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 1956–59 or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Evarring once. 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Licensed Practical Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Sherman Campbell Margaret Delores Beavers ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Shirley Harrison (Spouse) 7523 Dogwood Road, Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/12/2010 Lake View Mem. Park Sykesville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL. P.A. Harget rian M00764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Severe Dysphagia Approximate Interval Between Onset and Death mmediate Cause (Final Physician rest brown disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Midbrain Cerebral Infarction Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans ICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical CERT IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) signed by the a t be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should Completed 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Z Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 33a) (Type, Print) Aberry Parks

31. Date filed (Month, Day, Year)

FEB 19 2010

DHMH 17 Rev 1/2001

State Registrar

Box 68760. P.O. Records, Division of Vital

Maryland

Baltimore,

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician 230 17 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Good Samaritan_Hospital Baltimore City If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye January 22, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year 1 🔀 M 2 🗆 F 66 212-44-5334 **Director** Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7261 Eden Brook Drive Apt. 302 21046 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: White à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Johns Hopkins Elementary/Secondary (0-12) College (1-4or 5+) Security Guard University 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hagopian Simmons George ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any injury or other tra once. Kingsville, Maryland 21087 Mrs. Lucy Hagopian - Sister 7428 Milardo Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Feb. 22,2010 Glen Burnie, MD Glen Haven 22. Name and Address of Facility Baltimore, Maryland 21214 21. Signature of Funeral Service Licenses taul h Harbock 5305 Harford Rd. Leonard J. Ruck, Inc. 23a. Part 1. Enter the disease, or complications that "fused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician; The law requires that the death certificate be executed Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 No 1 ∐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Napatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: 2 Accident Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours To the Funeral 29a. Certifier 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . N'GWAW ST. SWITE 308

State Registrar

31. Date filed (Mont

gistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 04493 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 10, 2010 A. G. William Harvey February 8:40 /Medical 4a. Facility Name (If not Institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Silver Spring 3103 Farnborough Court Montgomery 9. Birthplace (State or Foreign Country) 1924 Great Britain 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, Y August 21, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Year) Days Months Hours 578-52-3352 85 Director Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "hocical Examinar mart be notified at Funeral Director 1 ☐ Yes 2 No Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country' 10e. Street and Number United States 20906 3103 Farnborough Court Great Britain Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Was Deces Armed Forces? 1 □Yes 2 📉 No 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🖾 No Specify. þ White 3 X Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Service Liason Aviation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Alfred Edward William Harvey Margaret Peachy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert F. Harvey / Son 12371 Taylorstown Road, Lovettsville, Virginia 20180 Pages 1 / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date February Department of Important: If its any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 18, 2010 Bethesda, Maryland 21. Signature of Fungral Service Licensee 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. Robert A. Pumphrey Funeral Home/Rod 300 West Montgomery Avenue, Rockvil 23a. Part 1. Fitter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertension /Medical Due to (or as a consequence of): **Examiner** Bladder Cancer Sequentially list conditions, if any, leading to immediate case. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Feta! death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Vear 5 ☐ Other (specify) P.O. 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records, Osteoarthritis, Hyperlipidemia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 1∐Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the fi 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifie 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD0059794 February 16, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Le Le Luu, M.D 1201 Seven Locks Road, #111, Rockville, Maryland 20854 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

FEB 19 2010

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Year Hazarides KOSTANTINO 2151PM ebruan 701 F Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Byrrei Baltimore Mord 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours Min (Month, Day, Year) 7 – 20 – 1937 Greece 216-50-1338 Director 72 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1

Yes 2 □ No MD Baltimore City 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 505 A Fairview Avenue 21224 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 💆 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify.White "natural", 3 Divorced 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 hand Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 6 Machinist Mechanics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Antonios Hazarides Palassa Lotides .. Page 1 and 2 should tment of Health and M tant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Soumela Hazarides -Wife 505 A Fairview Ave., Baltimore, MD 21224 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 2-19-10 Baltimore, MD 21. Signature of Funeral Se 22. Name and Address of Facility Bradley-Ashton Funeral Home 2134 Willow Spring Road, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CVD disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. (Disease or iinjury Date to for an a consequence of the Hospital or Attending Physician; The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: Physician/ 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav ☐ Pregnant ☐ Unknown Pregnant at time of death Other (specify) Year 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b page 2 sl autopsy performed? Yes 2 Nc After this certificate funeral director, pag 2 KNo 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 🔀 No မ 1 🗌 Yes 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident
Suicide 2 | No Investigation within 24 hours after death

To the Funeral Director;

completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🖫 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOO 28684 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

FEB 19 201

62. Registrar's Signature

Amend 19a, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Henry Hadley February 13, 2010 0626 A /Medical 13,2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Samaritan Boltimare
If Under 1 Year If Under 24 Hrs. HOSpita **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1**⊈M** 2□ F Months Hours Yrs. Director 240-26-2061 Usual Residence of Decedent 8-6-1925 84 N.C.10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Yes 2 No Director MD na Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1020 E. 33rd Street Iteme 23a 21218 Completed by Funeral U S 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ō Black 1 Yes X No Specify: land 21215²003 3 ☐ Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic even." Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Bethelehem Steel 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) 2 Martin Hadley Lydia Merchison Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene Hadley-Mother Wife 1020 E. 33rd Street Balto, MD 21218 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Murial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 2-25-10 Owings Mills, MD 21. Signature of Funeral Service Licensee March East F/H 22. Name and Address of Facility 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine to the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? s certificate hes b lirector, page 2 s autopsy performed? res 2 No 1 Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient 2 FeVOutpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this After thi 27. Manner of Death 1 Natural 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Scrussi us 31. Date filed (Month, Day, Year) FEB 19 2010 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5, per Fh g900 2/24/10 TT State of Maryland Department of Health and Mental Hygiene 04496 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2 Month 3. Time of Death Physician/ Zelma M. Harris 20^{Year}0 10:38a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George Takoma Park Washington Hospital 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 5250 gial Security Yumbe 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1 □ M 2 F Hours Director 50 Yrs unk 0/21/59 VA Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director PG Bowie MD 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1407 Peartree Lane 20721 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Completed 3 Divorced American Mental Hygiene. larked other than "natul atic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Group Homes Elementary/Seconday (0-12) College (1-4 or 5+) Private Nursing 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ပ t. Page 1 and 2 should be intrument of Health and Mentertant: If item 27 is marked jury or other traumatic e Jeremiah Clarke Clarice Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1407 Peartree Lane, Bowie, MD 20721 Delvin Gatling/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State cemetery, crematory or other place)
Emmanuel Bapt. CH. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2/27/10 Smithfield, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ari P 5126 Belair Rd, Balt. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Chysician disease or condition resulting in death) Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine signed by the attending physician and deed detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SLEFF 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 🗌 No 1 Tes Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No director, Be B 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 24 hours after death.
Funeral Director: After this leted filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the only one) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar's Signature FEB 19 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Shirley P. Medical Hachey **February** 2010 8:00 P^M 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5904 Cromwell Drive Bethesda Montgomery Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) 1 🗆 M 2 🕇 F (Month, Day, Year) OV 14, 1952 Months Days Hours Min. Director 005-56-0055 Nov Maine Usual Residence of Decedent 28a-f shov 10a. State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Tyes 2 TyNo Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5904 Cromwell Drive 20816 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Divorced Specify: Completed White 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within the and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William McLellan other traumatic Albert Alma Harma Kangas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important; If item 27 is any injury or other trau Robert G. Hachey/husband 5904 Cromwell Drive Bethesda, Maryland 20816 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place) Final Journey Crematory 2/19/2010 4 Donation 5 Other (Specify) Woodbine, Maryland 21. Sign we of Funeral Service Licens 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M sturios Homas M00957 Clarksville, MD 21029 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Metastatic Breast Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician ad for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🙀 No Year Day Pregnant at time of death signed by the a 1 Yes 2 5 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? certificate 1 Yes 2 No 1 🗌 Yes 2 🔀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year)

State

100

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Claudine Isaacs

20270

3800 Reservoir Road Washington, DC 20007

February 17, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

			1 - State Registrar	State of Maryla		rtificate of			eg. No.	04498		
1	Physic	an	Decedent's Name (First, Middle, Las JOHN W. HARVEY	(t)				2. Date of Deat Month FEBRUAR		3. Time of Death		
1	/Medi Examir	al	4a. Facility Name (If not institution, give	a street and number)				FEBRUAR	4c. County of Dea			
	Exami	iei	907 SHELLEY ROAD			TOWS			BALTIMO			
	Funeral Director		5. Social Security Number 6. Security Number 219–16–4336	ex 7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 7/18/19	Year) 9. Bir	thplace (State or Foreign ountry) RYLAND		
	9		Usual Residence of Decedent	140-	03 T				114			
	e Maryla a-f ahov	ctor	10a. State 10b. County BALTIN		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🛣 No		
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code		11	0g. Citizen of What C	ountry?		
	eath v	eral	907 SHELLEY ROAL	12 Was Decedent Ever in	115 121		1286	anifu Van er Na	USA 14. Race - Am	oriona Indian		
21215-0036	n 72 hours after death with the Maryland "naturat", or itama 23a or 28a-1 ahow stylcal Expr. uractivant be notified at		11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces? Way Yes 2 No 19 Forces or Dates: 1957	£ +0	f Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi			
15-(lete	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual Occup kind of work done	ation during most of works d)	ing	16b. Kind of Business			
212	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "any Injury or other traumatic avent, the Magnee.	Completed by	Elementary/Secondary (0-12) 12TH GRADE	College (1-4or 5+)			VE OFFICER		FEDERAL GO	VERNMENT		
Maryland	be file tal Hy d oth d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		,			
Z	d Men d Men narke	٢	WILLIAM J. HARVE		401-11			RIE HEIN		7. 0. (1)		
™	th and 2 so lith and 27 lare traum		WILLIAM HARVEY/SO		Testesia	SHELLEY F		SON, MD	City or Town, State, 21286	Zip Code)		
ore,	of Hea		20a. Method of Disposition **DBurial 2 Cremation 3	208	. Place of Dispo				20c. Location - City or	Town, State		
Baltimore,	t. Pag rtment rtent: I		4 □Donation 5 □ Other (Specify	,) F	PARKWOOD	CEMETERY	2/22/		BALTIMORE,			
Bal	Departiment of the particular		21. Signature of Funeral Service Licen				ss of Facility THE RAVEN BLV			HOME, P.A. 1286		
			23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as carpiac or respiratory arrest, Approximate interval Between									
6	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	.Arteriosch	enotic Co	nd lovescu	lan Dise	950		Onset and Death		
	Examiner			Due to (or as a cons	sequence of):							
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	ntificat ng phy as th		IT SELVING						(E)(j)).			
P.O. Box	The law requires that the death certain has been signed by the ettendingage 2 should be detached for use.	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ Fi 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year		
	w requires that been signed t should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of deat			
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10	g Physical dispersal di	n; To	27. Manner of Death	28a. Date of Injury (Month, Day Year)		1 3L DOX	4 Nursing Ho		nce 6 Other (Spe w injury occurred	icity)		
sior	Attanding I death. ictor; After y the funer	atlo	1 Natural 5 Pending 2 Accident investigation		Injury		Yes 2 □ No		,,			
Division	at or Att	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - Al building, etc. (Spe	t home, farm, str ocify)	eet, factory, office		28f. Location (Str City or Town	reet and Number or R , State)	ural Route Number,		
	To the Hospitat or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	ysician: To the best of my k iner: On the basis of exami and manner stated.	knowledge, death ination and/or inv	occurred at the tir vestigation, in my o	ne, date and place, a pinion, death occurr	and due to the ca ed at the time, da	tuse(s) and manner a ate and place, and du	s stated. e to the cause(s)		
}	To t To t	Σ	29b. Signature and title of certifier	1 100.4.	,	29c. Licens	6 6 7		9d. Date signed (Mon			
Ì		9	30. Name and address of person who c	completed cause of death (II	tem 23a) (Type,	Print)	-, 1	// A	bruary 1	1/2010		
	-0		31. Date filed (Month, Day, Year)	32 Registrar's Si	rimb!	6 17:11C	1 LaTher	ville,	M 9 510	93		
	Sta Registr		FEB 1 9 2010	32. Registrar's S	park							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ^ Morris Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) [uly 18 19 **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🖾 F Days Hours Min. Country) Director Yrs 216-58-9604 1958 laska Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County unk 10c. City, Town or Location unk Director 10d. Inside City Limits MD 1X Yes 2 No 10e. Street and Number unk 10f. Zip Code iink 10g. Citizen of What Country? Funeral USA 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married Marryland 21215-0036 white 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk subcontractor moving business Be 17. Father's Name (First, Middle, Last) 11nk 18. Mother's Name (First, Middle, Maiden Surname) unk 9 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessica Ambrose/stepdaughter Shady Ln; PO Box 298; Conolingo, MD 21918 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🖾 Other (Specify) In State 21. Signature of Roeral Sphice Sicenses Wade Nirector State and Andres of Facility Board; 655 W. Baltimore Street Maryland 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. 23a, Part 1. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ph sician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated second Due to (or as a consequence on. law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Dav 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed Yes 2 No Hospital or Attending Physician: The After this certificate 1 Yes 2 🗌 No **Division of Vital** Be (the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မ 1 🗌 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of De Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? Accident 1 🗌 Yes 2 🗌 No Investigation 24 hours after deal Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4006426 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

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			_ State Registrar		Cer	tificate of	Death	F	Reg. No.		
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	Funeral Director		5. Social Security Number 6. Sex 1 □	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Jan 18	9. Bi Co 3, 1930 Ma	rthplace (State or Foreign ountry) aryland	
	rland f show d at	tor	Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Loc	ation				10d. Inside City Limits	
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	s 23a or	Funeral Director	10e. Street and Number 1722 1723 Melbourne F	toad		10f. Zip Code	21222	*	10g. Citizen of What C United St		
920	ge 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Fur	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in I Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates.	lf.		Hispanic Origin? (Span, Mexican, Puert o Specify:		14. Race - Am Black, Whi Specify:		
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Baltimore,	Page 1 an Ient of He Int: If iter Iny or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Demation 5 ☐ Other (Specify)	emoval from State	o. Place of Dispos cemetery, crem oly Rosa	atory or other pla		Date .8/2010	20c. Location - City o	r Town, State	
Balti	permit. Page 1 Department of Important: If i any injury or once.		21. Signitured Funeral Period Inches	all'	Di Di		ess of Facility Funeral		Dundalk, I		
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P.O. Box 68760	the Hospital or Attending Physician; The law requires that the death certificate be the 24 hours after death. The 24 hours after death. This 24 hours after death. This cartificate has been signed by the attending physic mpleted filled in by the funeral director, page 2 should be detached for use as the beath of the funeral director, page 2 should be detached for use as the beath of the funeral director.	Physician/Medic	1 Live Birth 2 Fetal death 3 Ectopic pregnancy							te of delivery onth Day Year	
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			30. Name and address of person who cor RACHEL CHRISS LUI	S MO 4940	EASTE	RN AVE	NUE BA	IT MOR	E, MO 2	1224	
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